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NAVY**

# **Medicine**

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**May 1972**

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May 13, 1972, marks the 64th Birthday of the Navy Nurse Corps. The anniversary is especially significant this year as our nurses answer the challenge of improving delivery of health care services by dynamic and forthright action. Typical of this action is the new PNP — Pediatric Nurse Practitioner. Front cover photo was taken at the Well Baby Clinic, Naval Hospital San Diego, where an enthusiastic PNP is shown measuring an infant's chest circumference as part of the physical developmental assessment of an infant. The PNP is CDR F. Noble, NC, USN. The infant's mother (left) and student nurse in attendance (right), complete the pleasant clinical scene.

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## from the Chief

### TO THE OFFICERS OF THE NURSE CORPS

Today your skills, your initiative, and your personal interest are valuable factors in our efforts to provide high quality care to the men and women of the Navy and Marine Corps. Our Sailors, Marines, and their families are receiving exemplary nursing care from every Nurse Corps officer and you are vital members of the Navy's health care team.

As we strive to make our system of medical care more responsive to our patients and more professionally pleasing to our medical personnel we shall continue to need your talent, your devotion to duty, and your compassion for others for they are key elements in treating the ill and improving the lives of all.

I am pleased on the occasion of the Sixty-Fourth Anniversary of the Navy Nurse Corps to extend to each of you my personal regards and my very best wishes for a Happy Birthday.







DEPARTMENT OF THE NAVY  
BUREAU OF MEDICINE AND SURGERY  
WASHINGTON, D.C. 20390


ANNIVERSARY GREETINGS FROM DIRECTOR, NAVY NURSE CORPS

On 13 May 1972 members of the Navy Nurse Corps will join together to celebrate the Sixty-fourth Anniversary of the establishment of our Corps. It is an occasion in which we take pride as we reflect the years of devoted service which Nurse Corps officers have contributed to accomplish the mission of our Corps.

This year we stand on the threshold of a new era in which we will see exciting innovations in the delivery of health care. I am confident that Navy nurses will respond in meeting the challenges of these changes in a dynamic manner. Your loyalty, adaptability, and excellent leadership will continue to enhance nursing effectiveness in providing the best health care to Navy and Marine Corps men and women and their families.

I wish to take this opportunity to express my gratitude to each of you for your cooperation, understanding, and dedication to duty. As your Director, I am inspired by your aspirations, achievements, and unlimited capabilities.

Happy Birthday.

  
ALENE B. DUERK  
Captain, NC, USN

DEPARTMENT OF THE NAVY  
BUREAU OF MEDICINE AND SURGERY  
WASHINGTON, D.C. 20380



# **THE NAVY PNP**

## **Pediatric Nurse Practitioner**

By CDR Frances A. Noble, NC, USN; LT Donna M. Quinney, NC, USNR;  
and CAPT John E. Schanberger, MC, USN.\* Nursing and Pediatric Services,  
and the Clinical Investigation Center; Naval Hospital, San Diego, California.

When a parent brings a child to the Pediatric Clinic at Naval Hospital, San Diego, the child's health may be assessed by a Navy Pediatric Nurse Practitioner (PNP). The PNP is able to function most effectively in the Well Baby Clinic, Pediatric Screening Clinic, and Coronado Annex of this hospital, utilizing a firm foundation in pediatric nursing and newly acquired nursing skills. Working in association with and under the supervision of the pediatrician who is present, the PNP evaluates the child's health and psychosocial make-up.

The question most often asked of the PNPs by other staff members at this command is, "What are you two doing over there in the clinics and on the post-partum wards?" The answer is best expressed by citing several illustrative cases recently seen by the PNP.

An 18-year-old Filipino mother, when asked in the Well Baby Clinic if she had encountered any problems

at home in caring for her chubby six-week-old infant replied, "I'm worn out!" Further inquiry into the infant's history revealed good reason for this statement. The infant's need to suck had led to breast feeding for one and one-half hours out of every two hours, day and night. The baby had gained three and one-half pounds since birth. His weight was located at the 97th percentile on the growth chart, while his height remained in the tenth percentile. On physical examination he appeared exceedingly well nourished. In her eagerness to be a "good mother" to her baby, this young lady had misinterpreted her infant's every waking movement as a sign of hunger. The baby was rapidly developing a beautiful sense of trust in this setting, of course, and as a result he babbled and cooed delightfully. The mother had no one at home with whom she could talk; her own mother was still in the Philippines. The PNP was able to point out many features of normal infant behavior, thereby relieving the mother of excessive feedings and enabling her to relax while attending to other routines in the home.

Cases such as this are not at all infrequent, since

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The opinions and assertions contained herein are the private ones of the authors and are not to be construed as official or as reflecting the views of the Navy Department or of the naval service at large.



PNP LT Donna Quinney, NC, USNR, (right) completes medical history of contented toddler prior to examination.



Developmental assessment of a handsome 6-month-old infant is accomplished by PNP LT Quinney (right) with aid of mother (center).

many parents and grandparents support the concept that a fat baby is a healthy baby, not realizing that excess fat results in much more work required of the heart throughout infancy and childhood as well as adulthood. Additional assistance for this mother was provided by referral to the Navy Relief Society Visiting Nurse.

A second illustrative case was that of a robust six-year-old boy who was brought by his mother to an outlying clinic because of the recent development of abdominal pain and frequent headaches. Physical examination was within normal limits, as were the results

of appropriate laboratory procedures. Evaluation of the social history by the PNP disclosed that the boy had previously shown every evidence of being happy at home and at school, until the recent return of the father from overseas duty. The happy parents became busily occupied in planning the building of a long-awaited new home. The boy's most recent episode of abdominal pain and headache seemed to have been precipitated by a trip to the barber shop escorted by the father, and a resulting butch haircut. The boy's peers at school were all wearing a very different hair style which was unacceptable to this father. In



PNP CDR Frances Noble, NC, USN indicates circumscribed skin rash while consulting with pediatric neonatologist LCDR Nick Tsoulas, MC, USNR (right).



PNP LT Donna Quinney, NC, USNR (right) examines six-month-old infant during Well Baby Checkup, and confers with LCDR Tsoulas, MC, USNR (left) concerning respiratory problem.

addition, the child learned that his family would soon be moving to another neighborhood and that he would attend a different school. Very little in the way of explanation had been provided.

A discussion of the psychosocial development of a six-year-old boy was presented to the mother. It was pointed out by the PNP that the child had previously been busily engaged in group identification, in addition to having been "the man of the house" prior to his father's return. The case was reviewed with the clinic pediatrician in accordance with established guidelines, and was managed in follow-up by the nurse practitioner.

In a third case, a tearful two-year-old was brought to the Pediatric Screening Clinic after the mother had remained awake throughout the entire night because of the child's constant crying. Cough and runny nose had been noted for one week, and some degree of fever had been suspected on the night of constant crying. Past history revealed that the youngster had received only one DPT and oral polio vaccine immunization because "she always had a runny nose when her shots were due." On physical examination a temperature elevation to 102° F was noted. The PNP observed that the tympanic membranes were inflamed, dull and bulging; the pharynx was injected. The

consulting pediatrician agreed with the diagnosis of bilateral otitis media, and prescribed antibiotic and decongestant medication. The child was referred for follow-up to the Pediatric Appointment Clinic in view of the past medical history. In addition, the PNP explained to the parent the consequences of proximity of the pharynx and eustachian tubes in a child of this age, and the frequent association of otitis media with upper respiratory tract infection.

The above cases are typical of those seen by the Navy Pediatric Nurse Practitioner, who is also known by the title of Pediatric Nurse Associate. Her functions differ somewhat from those of her civilian counterpart, because of the military setting in which her patients and their families reside. Follow-up evaluation must sometimes be accomplished by another PNP, by a pediatrician, or even at another medical facility.

Occasional separation of the father from the family, and movement of the family to another duty station, are common occurrences in many service families. The nurse practitioner counsels and supports accordingly. The degree of disruption noted is often related to the attitude of the family toward these situations. Since children take cues from their parents, the PNP emphasizes the positive aspects of a child's adaptability and the capacity to cope with new situations.

Hi Ho! — Six-month-old infant undergoes physical assessment during Well Baby Checkup, apparently well satisfied with the attentions of mother (left), PNP CDR Frances Noble, NC, USN (center), and student nurse (right).







Soon they will be old pros.—PNP CDR F. Noble, NC, USN, leads discussion on home care of the newborn infant attended by new parents.

The basic goal of the Navy Pediatric Nurse Practitioner has been to help meet the need for optimal health care for dependent children. Nursing skills and knowledge are employed, with emphasis on anticipatory, parental guidance. In addition to counseling, the PNP's capabilities extend into other areas of diagnostic, therapeutic and preventive pediatric care. Expectant parents receive guidance through prenatal counseling sessions. Perinatal counseling is provided on the post-partum wards.

Well child care, including serial Well Baby Clinic visits, takes up the major portion of PNP time at this command. The nurse practitioner also sees children in the Pediatric Screening Clinic. Significant medical, social and family history is evaluated, and a complete physical examination is performed utilizing the classic methods of observation, inspection, palpation and auscultation. Laboratory studies are ordered when

indicated. An effort to establish the clinical diagnosis is made, and appropriate consultations are obtained with the pediatrician who is in attendance.

CAPT Eleanor J. Maguire, NC, USN, Chief of Nursing Service at this command, has provided the planning and support that resulted in acceptance of the nurse practitioner in this area. The cooperation of many individuals on the Nursing and Pediatric Services has been a major factor in the successful development of this program.

The Navy Pediatric Nurse Practitioner is seen as an active participant in ambulatory pediatrics in the Regionalization of Medical Care Program, contributing most effectively to the health care team. This team is dedicated to helping every child enter adulthood in an optimal state of physical, intellectual and social development, allowing each to function in society at a most effective level. ☸

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### DRUG PROGRAM EXPANDED

Some 27 day care centers have been authorized in the U.S. and overseas in an effort to combat drug abuse.

Besides providing treatment and counseling for drug users, the 27 centers will also serve as contact points for local drug education specialists and drug exemption program representatives.

The majority of the 27 centers are already in operation, having been started by local commanders. However, the authorization gives added funding, and encourages similar programs at other commands.

Future plans call for local care centers centrally coordinated on a Navy-wide system.—NAVNEWS, Washington, D.C. ☸



## The OB-GYN Nurse Practitioner\*

By LT Frankie Lukey, NC, USNR,\*  
Naval Hospital, Portsmouth, Virginia.

How do you cope with a slippery, wet, wiggling seven-pound bit of humanity whose main purpose in life, at the moment, is to squirm out of your grasp? With only two hands, how does one manage to position the baby, suction the airway, clamp and cut the cord, and encourage breathing all at one time? Such is the dilemma which confronts the OB-GYN nurse practitioner going through her first delivery.

Last October, six nurses with a common interest in OB-GYN met for the first time at the Naval Hospital in Portsmouth, Va. We soon were aware that our group was composed of six individuals of varying ages, backgrounds and experiences; six unique personalities, each with different goals, could be identified.

At the end of the first week of classes, I was overwhelmed by the extent and depth of material we were expected to learn. Long hours at the library and even longer hours spent studying at home did not seem to be enough. It was during this time that the necessity of learning each cell by its first name escaped me, and I had doubts about my ability to learn it all.

Our first day in the clinic found us doing new prenatal physical exams, from head to toe. Dr. Meriwether, our instructor, had assured us that the basis for a good physical exam was carefully seeing, hearing, and feeling. This, I felt, was a shoo-in. I never had trouble in seeing, hearing, or feeling. It was during my first exam that I became blind, deaf, and lost all sensation in my hands.

As the weeks went by, the classes and clinics became a little less traumatic and I began to regain a bit of self-confidence. The anatomy lessons became more meaningful after seeing the pelvic organs firsthand in surgery. Perception and judgment of the size of pelvic structures, which always takes time and experience, became a little easier after observation in the operating room. Despite demonstration of the ovaries and spines, I've denied their existence during countless exams for months. (They did say it takes time, didn't they?)

The doctors with whom we work are very cooperative, friendly, and always willing to help us solve our daily medical crises. As we become more experienced, they are beginning to rely on our help in the clinic, particularly in Return OB, where we see as many as 97 patients daily. The degree of self-satisfaction increases as the doctors dismiss our liabilities of the first few months and now regard our assets. This is extremely important to us since the

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\*LT Lukey is presently participating in the OB/GYN Nurse Clinician Course at the Naval Hospital in Portsmouth, Va. (See U.S. NAVY MEDICINE 59:50, Feb 1972)

The opinions expressed herein are those of the author and cannot be construed as reflecting the views of the Navy Department or the naval service at large.

purpose of our existence is to relieve the doctors of the routine care of OB-GYN patients, allowing more time to spend with the complicated cases.

I've become aware that many patients seek more than just a rubber-stamp seal of health; they want to be treated as individuals. Even in a jammed clinic, we try to give them the attention they deserve. As a result of this effort, combined with our own insecure feelings, we are much slower than the doctors. Fortunately, many of the doctors understand this, knowing that we're striving first for quality. The quantity will improve later.

Since Portsmouth Naval Hospital is a cancer treatment center, we have the added opportunity to learn and work under CAPT Upton, an authority in this field. The Tumor Clinic reveals the scope and depth of this type of therapy, and the amount of paper work involved has a tendency to leave me in awe. Working with the colposcope has provided a better understanding of GYN pathology by detection of deviations from the normal in a pelvic exam.

Always important on a daily basis on the wards, teaching took on added importance in the Family Planning Clinic, which we have organized and are running. We were aware of the necessity of providing information on cancer, hygiene and contraception for large numbers of people. For me, the greatest reward in teaching lies in seeing the patients in the clinic on a one-to-one basis. Substituting facts for some old wives' tales, and hopefully allaying some fears of childbirth, give us a great deal of satisfaction.

Most of the time we are fully occupied with classes and clinics, but for one exciting week, each of us followed a doctor around during his entire duty day. This same schedule will be repeated again during the last two months of the course. This arrangement provided

for our introduction to the labor and delivery rooms. For me it represented the climax of hours spent in the clinic, and I wanted to be present at every delivery. The initial excitement paled a little, when at 0430, the empty beds in the labor rooms looked better to me than the filled beds in the delivery rooms. I had frequently heard of the long hours most OB-GYN doctors work, but supposed that the work probably wasn't too exhausting. My respect for their stamina increased with the hours I remained awake. After half-an-hour of sleep all night, even the usually very interesting grand rounds of CAPT Baker (our Department Chief), failed to keep more than one of my eyes open. Following that incident, I advised Dr. Vickerman, the doctor whom I was shadowing, that I should prefer selectivity during the early hours of the morning. The highlight of the week was delivering my first baby with the capable insistence and assistance of Dr. Geary.

In summary, while we have all weathered misgivings about our capabilities and what we were doing, it has been a most exciting and rewarding time for Kit Campen, Dotty Emter, Joyce Robel, Karen Oberhausen, Joyce Vickers and myself. I'm also certain that a leader, teacher, fighter, illustrator, listener, speller, and head cheerleader better than CDR Betty Meriwether, MC, USN, cannot exist.

We still have a few more months before graduation, departure for our new duty stations and whatever awaits us there. But before I go, I hope to be able to answer those patients who continually ask the same questions.

"Are you a doctor?"

"No, I'm an OB-GYN nurse practitioner."

"Well, what's that?"

"That's a very good question. We're sort of . . . . .  
ahh . . . . ." 🌸

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## NEW SHIP CONCEPT TESTED

It is believed that many ships of the future could be hidden under the sea.

According to an engineer at the Naval Underwater Center (NUC) here, the ships could be built of relatively inexpensive reinforced concrete. They would be of various types, including underwater helicopter and aircraft carriers, marble underwater dry docks and underwater cargo vessels.

Studies underway at NUC show that reinforced concrete may be used as the basic hull materials for limited-depth submersibles. Since many casts could be made from one master form, construction time and costs would be reduced.

The only part of the ship that would be above water would be a flat deck that would serve as the landing surface, and the big pillars supporting the deck.

There would be two of these pillars, and they would contain the elevators to raise airplanes and helicopters from the main body of the ship underwater to the landing deck above.

Currently, models of these concrete ships are being studied.—NAVNEWS, San Diego, Calif. 🌸

# **SELF-HELP PROGRAM**

## **USS Constellation Medical Department**



By **LT Robert S. Bolshazy, MSC, USN,\***  
**Medical Department Administrative Officer,**  
**USS CONSTELLATION (CVA-64),**  
**FPO San Francisco, California 96601.**  
**(Photos by PH2 R.G. Lieblein, USN)**

Attack Aircraft Carriers (CVAs) are the Navy's largest warships with the largest ship's crews ever assembled. The mission of such carriers is to provide air support for combat operations from a sea-staging area and to control the air space that lies within its area of responsibility. The CVA's Medical Department plays

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\*LT Bolshazy is now a student at the Naval School of Health Care Administration, NNMC, Bethesda, Md.

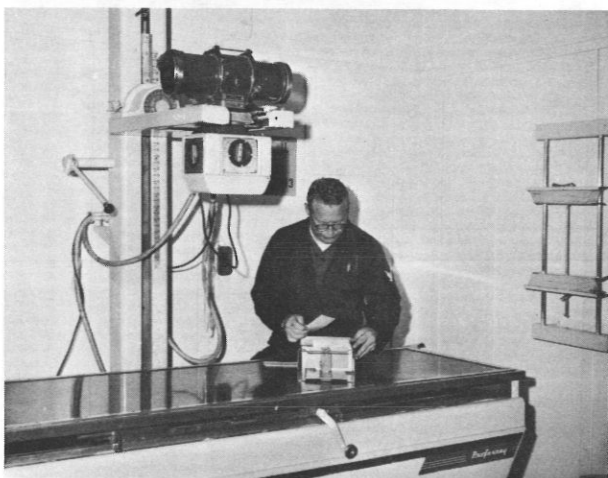
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a major role in accomplishing this mission by providing care for the air crew and officers and men supporting the carrier's flying mission, and by conducting an aggressive preventive medicine program to prevent illness and injury. The Medical Department in CONSTELLATION operates a small hospital (75-bed capacity) to support a population of more than 5,000 men, and it also conducts a full-scale industrial hygiene program. A ship of such size and complexity presents numerous occupational hazards.

This article reports on experiences of the Medical Department in CONSTELLATION during a recent nine-month overhaul. In order to improve facilities



and quality of medical care, the Medical Department identified specific areas in need of remodeling or refurbishing. The Engineering Department, with limited resources, was obliged to operate on a priority basis; work requests which were not of an emergency nature, or which did not directly effect the mission of the ship, received low priority. It was evident that an inordinate period of time would be required to accomplish the desired improvements if the Medical Department were to rely solely upon the Engineering Department. Confronted by the prevailing lack of resources to accomplish planned work before, during and after overhaul, the Medical Department elected to implement a Self-Help Program. With the exception of inpatient care, medical and clerical functions were continued without interruption and careful planning ensured that Self-Help projects did not interfere with the normal functioning of the Department.



HM2 Miller files cards in X-ray Room.

During overhaul the Medical Department integrated its Self-Help Program with the Ship's Force Overhaul Management System. The latter System was designed to accomplish all work needed and desired by the ship which could not be provided by outside assistance, i.e. the shipyard. During the period of overhaul, 90 percent of the Medical Department spaces were chipped, preserved and painted by Medical Department personnel.

#### *Relocation of the Clinical Laboratory*

The clinical laboratory formerly occupied a space measuring approximately eight by ten feet. This small space was clearly inadequate to accommodate assigned personnel and equipment. By relocation to an area formerly used for physical therapy and sanitation offices, the size of the clinical laboratory was increased to approximately ten by 20 feet. Some welding work



Clinical Laboratory

was performed by the ship's Engineering Department. Preparation, preservation and painting of the new space, together with installation of cabinets, deck tile and equipment were accomplished by Medical Department personnel who contributed more than 200 hours of work. The actual moving time was only about 12 hours during which three emergency procedures were performed, although the laboratory was unavailable for routine work.



HMC Crouch prepares to perform a lab test.

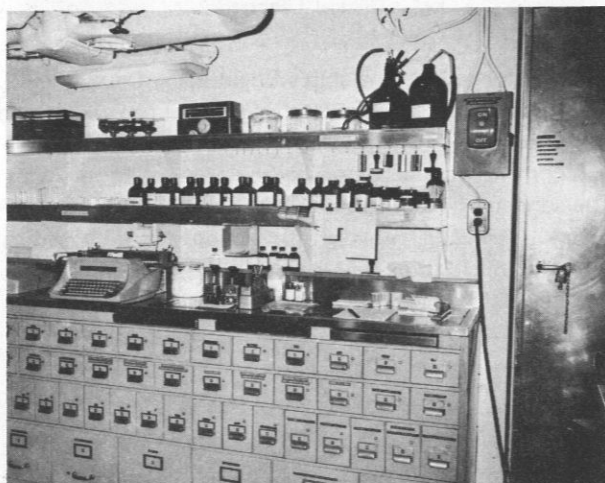
In order to complete the move with a minimum of inconvenience and disruption of routine work, advance planning, close coordination of all personnel and departments involved, and staffing were required. Diagrams were carefully constructed for proper placement of laboratory and sanitation office equipment. Detailed plans were studied and adjusted until an arrangement was devised to offer the most efficient use of available space. The space was adapted in such a way as to allow for efficient flow of work with orderly progression from beginning to completion, thereby minimizing wasted steps of laboratory technicians.

When staffing for Self-Help projects, it becomes necessary to identify Medical Department personnel with particular talents or skills that may be developed and

utilized. The Deck and Engineering Departments were most cooperative in training willing Departmental hands to chip paint, preserve surfaces, paint, install tiles, and perform minor general plumbing. Suitable schedules are required to determine the times when medical staff may appropriately be relieved of their normally-assigned duties to work in the Self-Help Program, without curtailing overall functions of the Medical Department.

### *Refurbishing Spaces*

The most striking change in appearance of the department was achieved through the use of different paint colors. The Medical Department reasoned that these were habitability spaces where the use of color



Pharmacy done in "Dental Blue"



Record office done in "Dental Blue"

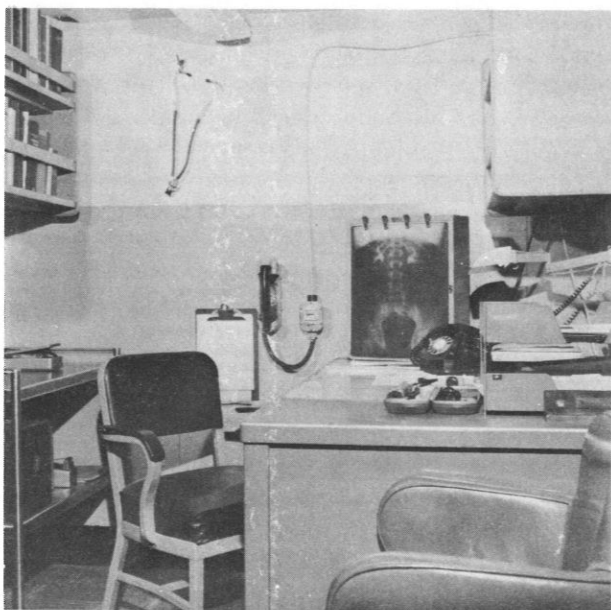


Sick call and treatment room

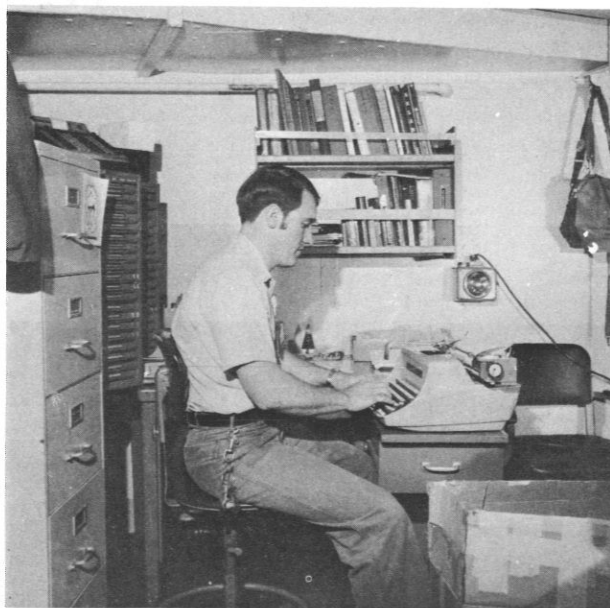
was permissible. Initial reaction to the colors was not favorable, but in time they were deemed to be pleasing and restful, providing an interesting change from the rest of the ship. "Dental Blue," a light blue color mixed by the Dental Department, lightened up the pharmacy and record office. "Sick Bay Green," created by the Medical Department, adorned the ward, a quiet room and three offices. Another ward was finished in peach and sandalwood; light yellow and pink were applied in each of two quiet rooms. Eventually the departure from conventional green and white paint was welcomed.

In the last analysis, it was considered that the use of color was probably the most practical and easily-achieved feature of all Self-Help projects accomplished

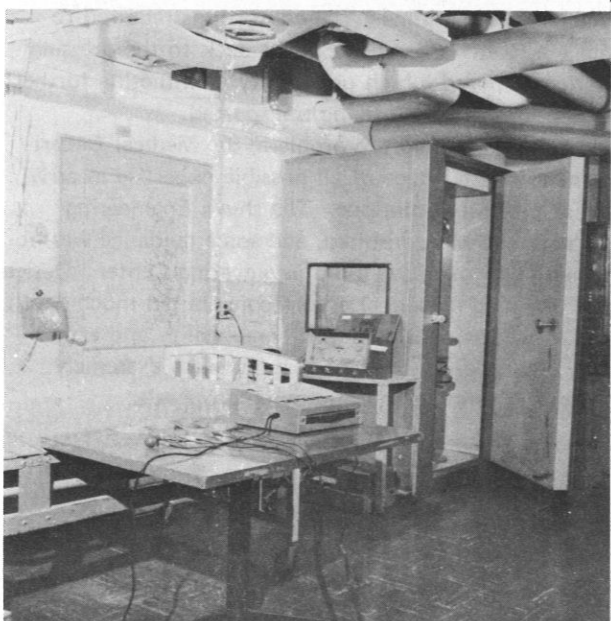




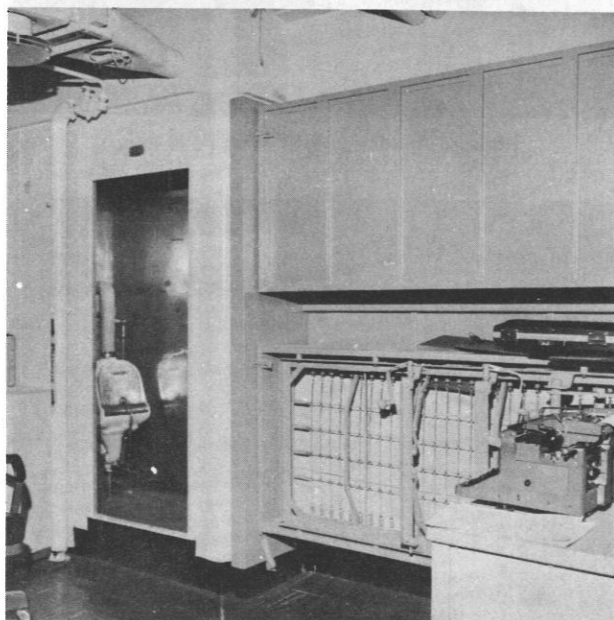
Office of Senior Medical Officer



HM2 Sitz prepares supply requisitions in supply office and isolation room No. 1.



Audiogram booth and EKG room



Isolation room No. 2 done in yellow

within the Medical Department. Employing different colors in paint and tile rendered the confinement of ill and injured personnel far more pleasant.

#### *Ship Alterations*

Ship alterations are primarily used to correct design deficiencies and to modernize a ship. It is a long and tedious process to propose ship alterations: first, specific problems must be identified; second, proposals are

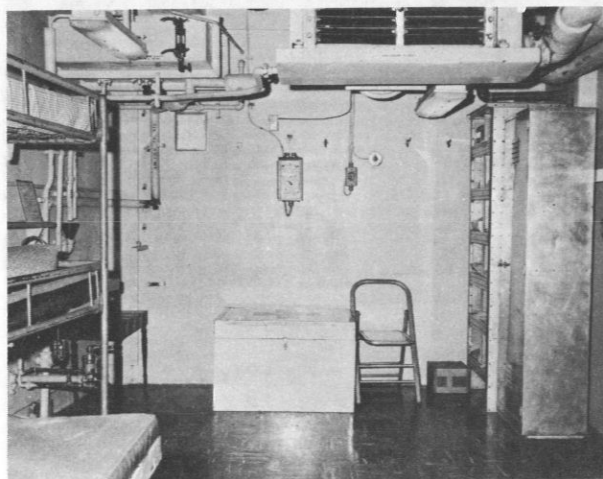
made and improved until the best solution is reached; third, the accepted proposal is aggressively pursued to obtain the necessary assistance from ship and shore personnel who accomplish the work.

#### *Alterations in Battle Dressing Station*

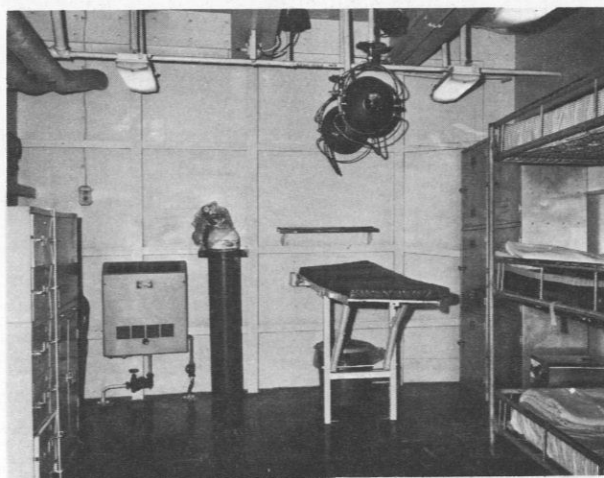
Arising from a deficiency in design when the ship was constructed, two problems were identified in connection with the battle dressing stations on the



Forward Auxiliary Battle Dressing Station



Aft View After Auxiliary Battle Dressing Station



Forward View After Auxiliary Battle Dressing Station

carrier. Stretcher access to the forward auxiliary battle dressing station was all but precluded, and the station itself was not large enough to accommodate more than one patient at a time. The contortions required to move a stretcher from the flight deck to the dressing station imposed a high probability of inflicting further injury to the patient being transported.

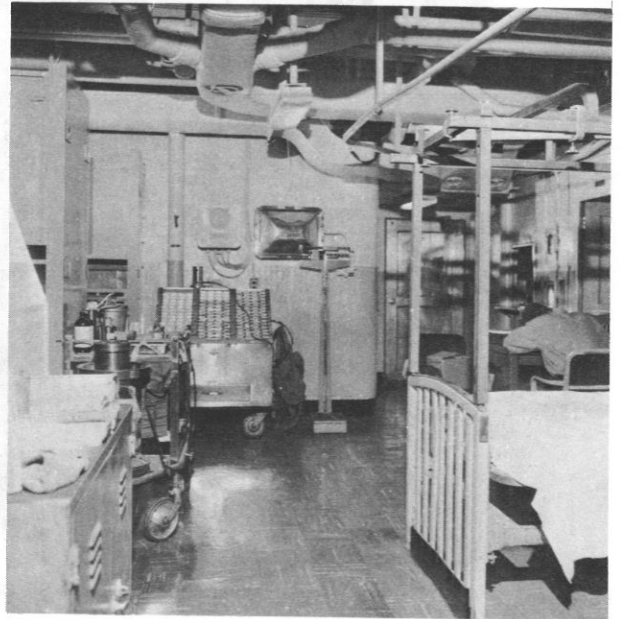
Having identified the problem, the Medical Department took advantage of all possible expertise in arriving at proposed solutions. The ship's Engineering Department was consulted, and some guidance was obtained from the Naval Ship Engineering Center. Design and planning personnel ashore contributed much depth and insight in considering the practicality and soundness of proposals; their suggestions were extremely helpful in refining and improving proposals.



Midships Auxiliary Battle Dressing Station



Supply storeroom, Forward Battle Dressing Station



Ward No. 1 Medical

After extensive consultation and exploration, it was determined that stretcher access would best be improved by building a ramp and installing an access through the skin of the ship in the port side forward. The plan was further developed to move the battle dressing station to the wardroom in the immediate vicinity. This offered the additional advantage of further enhancing medical capability by providing a large secondary sick bay in the event that the main sick bay could not be used for patient care. The ship's original plans did not allow for this eventuality.

#### *Alterations in Hospital Bed Facilities*

A second area proposed for alteration was Ward 1 (Primary Care Ward). The installation of an intensive care unit with additional hospital beds for the management of acutely ill medical and surgical patients has been proposed. Such a facility would improve the quality of medical care provided for the patients requiring constant nursing care around the clock, without disturbing other ward patients.

By identifying these needs and formally proposing the most practical solutions offered, the Medical Department has taken the first necessary steps to ensure that optimum quality medical care will be provided in the future.

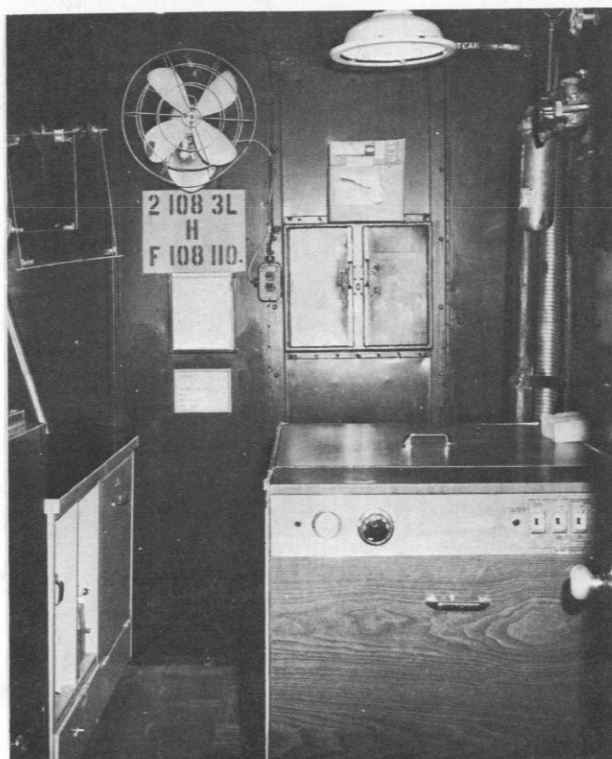


Operating Room

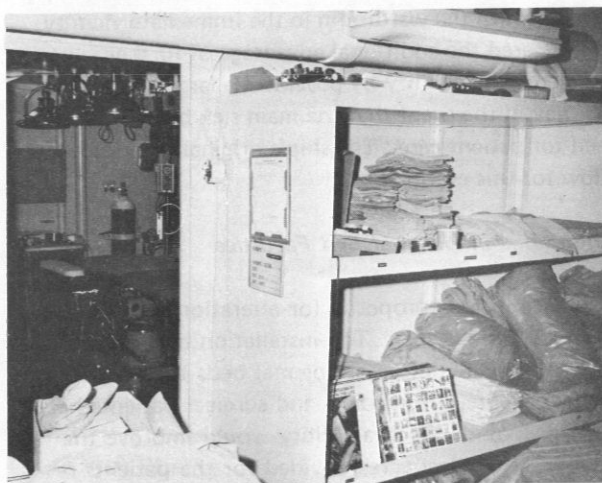




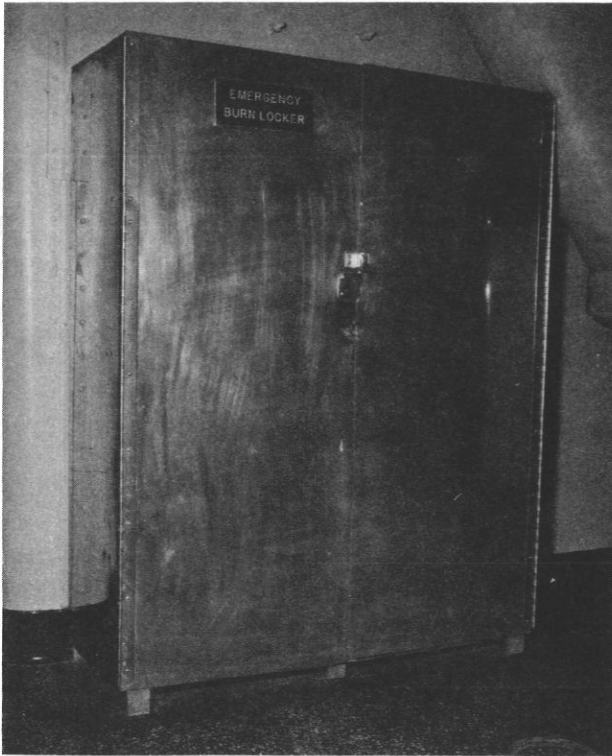
HM3 Sessions prepares SF 88s in Physical Examination Room



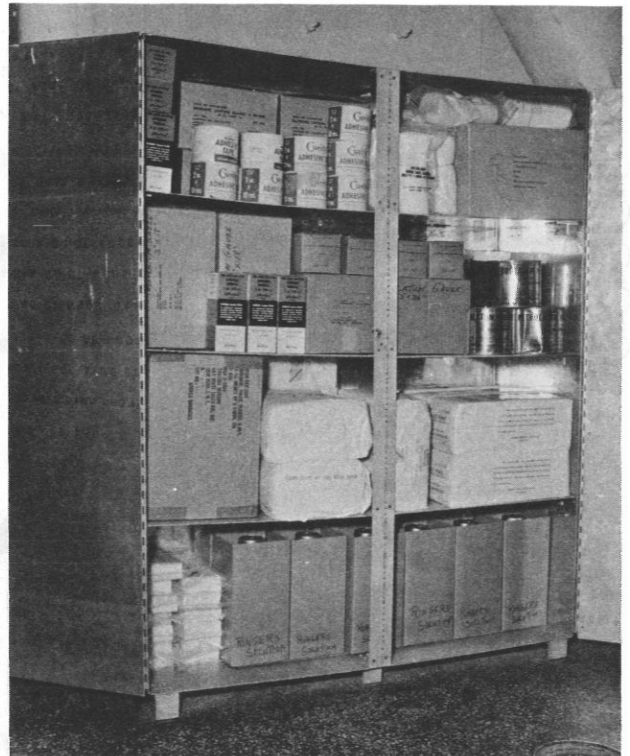
X-ray Darkroom



Central Sterile Supply Room



Emergency Burn Locker in Ward Utility Room



Contents of Emergency Burn Locker

### *Conclusion*

Self-Help programs can be effectively conducted by any medical department. The projects described above could be planned and accomplished over a longer period of time with the available resources and time in an operating CVA.

Innovation, planning and proper staffing are essential to transform ideas into accomplished fact. All Navy programs currently in effect, whether strictly oriented toward the Medical Department or not, should be used wherever applicable in resolving the problems encountered in the Medical Department. The obvious goal of Self-Help projects is to improve the quality of medical treatment and enhance the clinical management of patients afloat.

It is well for those who undertake Self-Help Programs to bear in mind that the Force Medical Officer can contribute a wealth of information which should be tapped by the Medical Department afloat. The Force

Medical Officer should be advised of problems identified and corrected in all ships of the type commands. His office can offer sound recommendations and contribute much that has been learned from past experience.

The Fleet Marine and Ship Support Division, BUMED (Code 49) is happy to provide assistance, and desires to be made aware of problems encountered by afloat medical departments in the area of plant deficiencies. In dealing with such problems and exploring their solutions, this Division has frequently had occasion to make suitable recommendations to the Naval Ship Engineering Center for present and future design improvements.

Self-Help is not an entirely new concept. Those with ingenuity, spirit and industry have long employed this approach to achievement. It is the climate surrounding the method that is revived. We are invited and urged to accept the challenge, to embrace progress in the delivery of medical care which must surely follow. ☸





## THE GASTROENTEROLOGISTS' CORNER

### HEPATORENAL SYNDROME

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The term hepatorenal syndrome currently implies a specific situation with distinct features and prognosis. Numerous types of renal disease may occur within the full spectrum of liver pathology, however, and the hepatorenal syndrome is not necessarily the most common among them. The other types of renal disease are often much more amenable to therapeutic maneuvers. Accordingly this paper will first review the full range of hepatorenal relationships, and will then explore in greater detail specific features of the hepatorenal syndrome.

The concept of renal impairment associated with liver disease goes back at least to the beginning of the last century. In 1806 there were scattered reports of high urinary concentrations of urea in patients with liver disease. In 1863 Dr. Austin Flint first noted that the urine volume in these patients was often reduced. Gilbert in 1901 noticed a reversal of the normal diurnal variation of urine output in cirrhotics. Finally, in 1932 it was Dr. Helwig who first proposed the concept

that renal failure in certain patients with liver disease was in some way related to liver dysfunction. Since that time much has been written about the pathology and functional changes in renal failure associated with liver disease, under the term "hepatorenal syndrome." Until rather recently the term was frequently used to include all types of renal disease associated with liver failure so that a comparison of earlier data with more recent studies often leaves one a bit confused. In order to clarify this confusion and to arrive at a better understanding of the definition of hepatorenal syndrome as it is employed today, it is helpful to examine step-by-step the various causes of renal failure in the patient with liver disease. These are summarized in Figure 1.

*Separate Liver and Kidney Diseases:* In 1951 Patek described 14 cases of typical acute glomerulonephritis out of 200 consecutive patients with hepatic cirrhosis. In all well-documented cases the diagnosis of cirrhosis had preceded the diagnosis of nephritis. Seven of these patients eventually came to postmortem examination and all presented findings of nephritis of the proliferative, intercapillary type. This represented an 11% incidence of nephritis in all those

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The opinions expressed herein are those of the authors and cannot be construed as reflecting the views of the Navy Department or of the naval service at large.

cirrhotics who were autopsied. Unfortunately, no one has since been able to arrive at similar findings. There have been numerous other studies of the kidneys in patients dying with cirrhosis but, as will be noted later, none of the findings have been quite so specific as those described by Dr. Patek.

There are also congenital disorders, in addition to separate acquired liver and kidney diseases. Polycystic disease, involving both the liver and kidneys, is probably the most common of these congenital disorders. Most of the congenital disorders, however, are not compatible with a very long life and tend to remain in the realm of the pediatrician and neonatologist.

**Systemic Disorders Simultaneously Involving Both Liver and Kidney:** There are innumerable diseases in which there may be simultaneous involvement of both liver and kidney. A complete listing of all such diseases is beyond the scope of this paper. However, mention of a few of the more common of these diseases is worthwhile to indicate the wide range of etiology covered and to serve as a reminder when evaluating a patient with both liver and renal disease. Among infectious diseases should be included: viral hepatitis, leptospirosis, schistosomiasis, mumps, and yellow fever. It is obvious that any bacterial, fungal, viral, or other infectious agent which invades the blood stream may produce simultaneous involvement of both the kidney and the liver. Certain drugs and chemicals have frequently been reported to cause simultaneous liver and renal failure. Among these are carbon tetrachloride, chloroform, and DDT. Neoplastic diseases, especially lymphomas, may also produce this situation. Amyloidosis, a not uncommon finding in the late stages of many chronic diseases, frequently involves both the kidney and the liver.

**Primary Kidney Disease Affecting Hepatic Function:** Does kidney disease produce liver dysfunction? Actually only one such situation has been described in detail, so this must surely be extremely unusual.

In 1965 Lemmon described the case of a 45-year-old female who presented with anemia, splenomegaly and fever of unknown origin. Routine liver function tests revealed evidence of liver disease but liver biopsy examination was normal. Subsequently the patient was discovered to have a unilateral renal mass and a left lower lobe lesion was detected on her chest X-ray examination. At laparotomy the renal mass proved to be a hypernephroma and the involved kidney was removed. Following temporary clinical improvement, similar signs and symptoms recurred. The lung lesion, which had shown evidence of growth in the interim, was subsequently removed and found to represent a metastasis from the hypernephroma. Following this surgery the patient gradually improved and remained well, with a return to normal of all her liver function tests. Numerous liver biopsies, including two open biopsies performed at surgery, were all said to be within normal limits. It was postulated that the liver dysfunction was in some way caused by the hypernephroma, that such a situation is probably common in cases of hypernephroma and should be investigated more carefully in the future.

**Primary Liver Disease Affecting Renal Function:** It is appropriate to consider next those situations which may arise as a complication of liver disease, or its treatment, and which may result in renal damage or failure.

Too vigorous treatment of ascites with diuretic agents or paracentesis may result in acute tubular necrosis or hypokalemic nephropathy. Pyelonephritis is

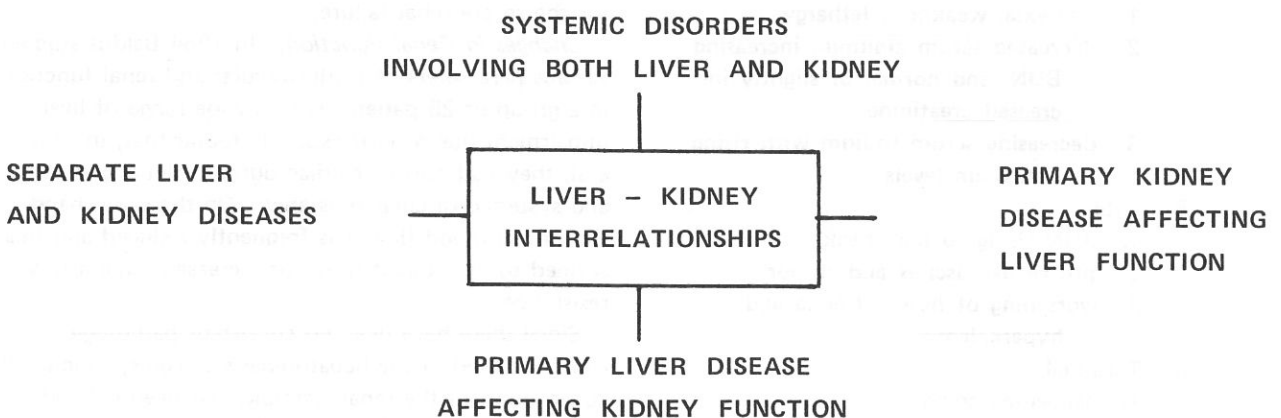


Figure 1.—Schematic Representation of possible interrelationships of liver and kidney disease.

a not uncommon finding in patients with advanced liver disease and probably results from the use of indwelling urinary catheters as well as the altered immune state of many of these patients. Neomycin, and other medications frequently used in such patients, are nephrotoxic in high doses.

Finally, we arrive at a consideration of spontaneous renal failure associated with severe parenchymal liver disease, or the "hepatorenal syndrome." To establish such a diagnosis it is of course imperative to rule out the previously mentioned causes of renal failure in the patient with liver disease. There are also distinct clinical features of the true hepatorenal syndrome which suggest the diagnosis.

*Natural Course of the Hepatorenal Syndrome:* This entity occurs in the patient with chronic cirrhosis, usually severe. Other complications of cirrhosis, including hepatic coma and portal hypertension, are frequently recorded. Jaundice may or may not be present but hepatic function is severely impaired by most clinical and biochemical criteria. Initially, fatigue and anorexia are associated with hyponatremia, hypokalemia, hypochloremia, and elevated BUN (blood urea nitrogen) and serum creatinine values. Later patients may experience vomiting and thirst. Simultaneously the biochemical abnormalities become more pronounced. With further deterioration depression of the sensorium, EEG (electroencephalographic) changes, and elevated blood

ammonia concentrations consistent with, and indistinguishable from, hepatic coma appear. Oliguria and arterial hypotension become evident and deepening coma, with an unfavorable outcome, is the rule. Features of hepatic failure still predominate, and death not infrequently results from massive GI (gastrointestinal) hemorrhage.

How often does this situation arise? Unfortunately no good statistical studies have been reported, probably because clinicians do not always agree on the definition or etiology in specific cases. Chalmers, in a review of this problem in 1960, stated that almost every patient with progressive cirrhosis had terminal renal failure and uremia. Shear, in another review of the problem in 1965, noted that more than 50% of his patients dying from complications of cirrhosis had evidence of renal disease.

*Pathology of the Kidneys in Hepatorenal Syndrome:* Baldus reviewed a series of 25 patients with hepatorenal syndrome, 11 or 44% of which came to autopsy. Several nonspecific findings were present which varied widely from case to case. No consistent histologic changes were found and none of the abnormalities encountered were believed sufficient by the author to account for the impairment of renal function. Salomon et al., on the other hand, in a review of 24 patients with hepatorenal syndrome, stated that all had abnormal glomerular changes as demonstrated by electron microscopy. These changes included deposits on the capillary wall and mesangium, thickening of basement membrane, and increased mesangial matrix. However, like other morphological findings, these glomerular changes were not correlated with abnormalities of renal function or with the type, duration, or severity of the hepatic disease. It seems to be the opinion of most hepatologists at the present time that the changes found in the kidneys of patients dying of hepatorenal syndrome are nonspecific and probably cannot account for the severe renal failure.

*Changes in Renal Function:* In 1964 Baldus studied various parameters of cardiovascular and renal function in a group of 25 patients with a wide range of liver impairment due to cirrhosis. He found that, in general, they had normal cardiac output, blood pressure, and systemic vascular resistance. On the other hand, their renal blood flow was frequently reduced and this seemed to be a direct result of increased renal artery resistance.

Since there have been no consistent pathologic changes found in the hepatorenal syndrome, functional constriction of the renal arterioles has been offered as an explanation for the observed changes in renal function. Recently more sophisticated studies have seemed

**TABLE 1.—CLINICAL FEATURES OF HEPATORENAL SYNDROME**

- I. Antecedent Factors
  - A. Evidence of advanced hepatocellular failure
  - B. Ascites; progressively refractory to therapy
- II. Three Phases
  - A. Early
    1. anorexia, weakness, lethargy
    2. decreased serum albumin, increasing BUN, and normal or slightly increased creatinine
    3. decreasing serum sodium with rising potassium levels
  - B. Late
    1. BUN rising to high peak
    2. progressive ascites and stupor
    3. worsening of hyponatremia and hyperkalemia
  - C. Terminal
    1. deepening coma
    2. oliguria
    3. hypotension



to confirm this hypothesis. Epstein, et al., studied 15 patients with cirrhosis and varying degrees of renal functional impairment using the radioactive xenon wash-out technique and renal arteriography. They found no apparent correlation between individual biochemical parameters of liver function and the development of oliguric-renal failure or changes in renal hemodynamics. There was an excellent correlation between the decrease in the percentage of blood flow to the renal cortex and the magnitude of renal functional impairment as measured by the creatinine clearance. The patients studied showed extreme degrees of variability and irregularity of xenon washout, in contrast to patients with renal failure from other causes. This suggests extreme hemodynamic instability which in turn suggests that the renal ischemia is secondary to active vasoconstriction. Consistent reversal of all the vascular abnormalities in the kidneys of the five cirrhotic patients studied at postmortem examination by renal angiography, provided further evidence for the functional basis of renal failure mediated through active renal vasoconstriction.

In further studies involving the same group of cirrhotic patients, Epstein showed a good correlation between elevations of plasma renin levels and decreased GFR (glomerular filtration rate). This was felt to be consistent with the concept that renal arteriolar perfusion pressure is decreased in cirrhotic patients with functional renal failure and that this results in renin release, either by a direct effect or through some alteration in intrarenal sodium handling.

*Etiology of the Hepatorenal Syndrome:* What, then, could be the direct cause for this change in renal arteriolar pressure? Two lines of thought have been pursued, unfortunately without much success.

1. Humoral basis: Vasoactive compounds normally inactivated by the healthy liver, but capable of causing renal arteriolar constriction, have been measured in body fluids from patients with renal circulatory failure; none have been found in excess. Recent studies have demonstrated elevated venous renin activity in cases of cirrhosis. It has been suggested that this may come from several sources, such as: increased release from splanchnic bed; decreased inactivation from impaired liver function; or, as noted above, from the kidney itself as a result of renal arteriolar constriction. Although alterations in the renin-angiotensin-aldosterone system may explain some of the fluid and electrolyte changes found in the hepatorenal syndrome, angiotensin would not seem to be the sole mediator of the renal failure in view of the extremely abnormal interlobar and arcuate arteries demonstrated in the angiograms of these patients. Angiotensin, as shown in other studies, does not affect this order of vessels.

2. Neurogenic basis: A relationship has been considered between the renal and hepatic blood flows mediated through the autonomic nervous system. Indeed, in experimental animals a reduction of hepatic blood flow impairs renal blood flow and this effect is alleviated by sympathectomy. However, as yet there is little to support the application of this theory to humans with liver disease, and preliminary efforts with splanchnic block have not been therapeutically rewarding. Also, in the angiographic studies by Epstein et al. mentioned before, phentolamine infusion into the renal artery did not significantly alter renal hemodynamics. The authors state that this result suggests that increased sympathetic nervous system activity is not responsible for the active vasoconstriction and cortical ischemia.

*Prognosis and Therapy:* The hepatorenal syndrome is generally considered to carry an almost universal fatal outcome. Death generally occurs within days to a few weeks, with deepening hepatic coma and/or gastrointestinal hemorrhage as the terminal event. Those cases which recovered seemed to have made clinical gains following demonstrable improvement in liver function. Prognosis, therefore, is often related most clearly to the reversibility of liver function. Standard therapy is thus designed to allow maximal time for recovery of hepatic function, as well as to prevent and treat any ancillary problems which might further compromise renal function (Table 2). Other complications of liver failure (GI hemorrhage, hepatic coma) should be treated vigorously. Fluid intake and dietary sodium should be restricted, especially if 24-hour urine output is less than 500 ml and serum sodium is less than 130 mEq/liter. One should avoid overuse of diuretic

TABLE 2.—THERAPY OF  
HEPATORENAL SYNDROME

1. Measures are designed to permit maximal time for the recovery of hepatic function upon which the outcome appears to depend.
2. Other complications of liver failure (GI hemorrhage, hepatic coma) should be treated vigorously.
3. Restrict fluid intake and dietary sodium — especially if urine output measures less than 500 ml/24 hours and serum sodium measures less than 130 mEq/liter.
4. Avoid diuretics — may decrease plasma volume and restrict GFR even further.
5. Other causes of renal disease should be searched for and treated vigorously — UTI (urinary tract infection), hypotension, hypokalemia, etc.

therapy since any decrease in plasma volume may restrict GFR even further. For the same reason, diminished blood volume secondary to anemia should be cautiously corrected, preferably with packed red cells. Other causes of renal disease such as urinary tract infection, obstructive uropathy, hypokalemia, etc., should be searched for and treated vigorously. More drastic measures such as cross transfusion through the livers of various animals, and intravenous reinfusion of peritoneal fluid, are still experimental. The hazards involved do not justify their routine use at the present time.

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RADM George J. Coleman, DC, USNR-R (standing sixth from the right in front row), and 28 other Ready Reserve dental officers, attended the Naval Reserve Dental Indoctrination and Orientation Seminar conducted in the Bureau of Medicine and Surgery, 13-17 March 1972. CAPT Paul E. Farrell, DC, USN, of the Personnel Branch, Dental Division (standing on extreme right in front row), conducted the annual Seminar attended by commanding officers, executive officers and members of Naval Reserve Dental Companies, and dental officers attached to the Training and Support Component of the Naval Reserve. ☞



# Military Medicine — A Therapeutic Dilemma

By CAPT Donald W. Robinson, MC, USN,  
Commanding Officer, Naval Hospital, Charleston, South Carolina.

The day when the need for medical care in the military could be simply expressed by "keeping the most men manning guns as possible" has long since past. Today the requirements are as complex as the hardware of war and continue to expand with the increase of medical knowledge.

The obvious requirements of providing remedial and preventive health care to our troops on a day-to-day basis has always been with us. The character of this has changed little, with the exception of more and more emphasis on the preventive aspects, and it represents a less challenging portion of the total effort.

Battle plans of war for medical care delivery and logistics occupies a few people on a continuous basis and requires an expertise that is in short supply.

A third unique medical requirement is type-specific research in both the basic sciences and clinical disciplines to determine man's capabilities and resistances as related to the ever-increasing sophistication of military hardware and weapon systems. A significant quantity of this work can be performed by the ancillary medical sciences and in civilian institutions.

Medical research which is applicable to the military and its special problems can be generated and utilized from both the academic and industrial spheres. But again the need for specialized military medical person-

nel, for which there is no substitute, will arise from time to time.

The fourth requirement is the provision of health care to the "supernumeraries," the rapidly increasing active duty dependents and the retired members and their dependents. This, which started as an "add-on" to provide additional fringe benefits, has insidiously come to consume a majority of the medical assets of the Department of Defense. It has also generated a majority of the problems which face military medicine today.

Provision of medical care of dependents and retired would obviously appear to be available from the civilian sector. This, however, is not always the case when one remembers how often large military complexes may totally overtax a relatively small or remotely isolated civilian community. If such medical benefits are to be promised, then provision for delivery must be assured.

The modality of health care delivery is being debated at all levels. The diminishing defense dollar coupled with nationally inadequate numbers of medical personnel, compounded by military dislike, has created a problem of huge magnitude.

The daily routine of occupational health care could be partially provided by civilians if in adequate supply. This however would not serve our deployed forces who must have a highly mobile and frequently a highly specialized capability. The submarine force, the aerospace personnel, the marine and amphibious

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personnel, to mention a few, demand medical care which is uniquely "military" and not available on the civilian market.

In times of war we have historically relied upon mobilization of civilian practitioners to provide for our additional needs. The lessons learned from highway trauma are applicable to the trauma of the battlefield, but new knowledge must be acquired to generate a "complete military physician." Specialized training is frequently required with time representing an expense which sometimes cannot be afforded. Mobilization itself is a time-consuming process. Medical support plans for wartime can only be provided by a cadre of dedicated personnel who have acquired their special knowledge through years of unique experience and analysis of historical data.

The military commander has the responsibility of seeing that his troops receive quality medical care when needed. He wants and expects that his personnel will receive expeditious attention. The peculiar nature of the military mission not infrequently modifies the form of appropriate medical care. Such factors compound the difficulty of using scarce civilian resources and point up the desirability of dedicated medical care which is accountable and responsive to both the patient's desires and the commander's requirements; not infrequently the latter are slightly at odds, or totally different. The traditional "doctor-patient relationship" must assume a triangular configuration to include the employer. An independent civilian will not always fill the role. Generally the shortage of specialized occupational medicine physicians is even more acute than physicians. Frequently, by necessity this job is filled by generalists who are handicapped or limited in their capabilities and who seek steady employment of an undemanding nature, with little responsibility.

Deployed forces in peacetime are frequently small units in remote areas. The requirement for a physician is episodic at best in as much as routine medical administrative matters can be adequately handled by paramedical personnel.

It is conceivable that with advancing skills in monitoring bodily functions and transmitting such information electronically, the physician may gain a remote presence for purposes of diagnosis and pharmacologic therapy. There appears to be no substitute, however, for the physical presence of the surgeon when his technical skills are required. The concept of medical "roosters" in regional centers, who can be called upon for deployment whenever appropriate, improves the utilization of limited resources but does not entirely solve the problem. Medical air evacuation systems are

no absolute guarantee of timely care.

The individual service member as a patient desires a physician very similar to the average civilian. He would like to have continuity of care by a medical officer who could fill the role of the traditional family doctor and, hopefully, provide similar care also for dependents when at home, with referrals to specialists in hospitals only when absolutely necessary. This idealistic situation is seldom realized but is achieved in some areas of the Navy where there are heavy fleet concentrations and large hospitals. Changes in assignments make this relationship unstable under most circumstances.

An episode of serious illness or prolonged hospitalization usually impresses the patient with the high quality of military medical care. It is unfortunate that many poorly informed individuals receive a contrary impression when their contact with the medical department is superficial and for relatively minor routine matters. Too often they see the outpatient staff as disinterested, curt, officious people who do not measure up to the courteous, compassionate and concerned staff who provide their services for a high fee in the civilian physician's office. The austere and drab surroundings of the military setting likewise compare unfavorably with the plush decor of the private practitioners' suites. Neither do they realize that over 60 percent of the physicians they encounter are civilians practicing medicine in uniform to fulfill their service obligation. They arbitrarily condemn "military doctors" as inferior to "civilian doctors," not thinking that most likely these are the same professionals they so admired last year and will again next year. All medical departments recognize the need for more courteous and considerate attitudes. The social amenities are a necessary adjunct to all medical care. Unfortunately, this garnish is all too frequently forgotten and without these secondary niceties the best of medical treatment suffers. Few laymen can positively distinguish between excellent and mediocre diagnostic acumen and courses of therapy but we all recognize tact, compassion and politeness. The sick and the anxious are the most demanding of these features of public service. In the fear and hostilities born of anxiety or suffering, these patients occasionally invite a kind of attention that is less than the occasion requires. The healing arts are difficult to teach and tedious to learn. A few short weeks in Hospital Corps School, or indeed a few short years in nursing or medical school does not guarantee gentleness in word and deed. It is easier and faster to produce a competent technician than a wise and tactful "healer." The civilian sector has the advantage of stability and a greater monetary incentive.

Another frequent complaint of the military patient is the lack of coordination of his total care. In some obscure condition the patient may be sent from one specialist to another and have every bodily function tested and monitored. He is exposed to the very best that modern medicine has to offer but there is no single person who directs an orderly course or eventually puts the pieces of the complex puzzle together. With a change of duty and a transfer to another medical facility the whole exhaustive study may be repeated because of an inherent unwillingness of physicians as a whole to accept the validity of studies performed by persons unknown.

It is frequently the case that the serviceman and his family acquire their initial exposure to health care while on active duty and they have no sound basis for a comparison of civilian and military medical practice. If LT Smith is not the prototype of Marcus Welby, M.D., the patient feels that he is not getting his rightful due.

The military medical officer has his own unique problems. As a result of the many retention studies, much has been written on this subject. The many reasons for leaving the service have been chronicled but usually those expressed leave much unsaid. The true reasons do not often fit in a neat little package.

The average physician entering the service usually comes directly from school or postgraduate training. He is highly idealistic and has yet to face the cold realities of the average practice. His academic milieu has consisted of one complicated case after another, with many bizarre and exotic conditions making his day full of exciting and stimulating challenges. The cosmopolitan setting offers a great variety of diversions for his occasional time off. He is totally unprepared for the routine day-to-day "bread and butter" type cases which will occupy the vast amount of his time. His life style is changed by what are often regarded as restrictive and oppressive regulations that dictate to some extent his dress and grooming, coming and going, and social customs. If a specialist, he frequently finds that from time to time he will have to stand a "watch" in the Emergency Room and do general practice in which he feels uncomfortable and unjustly utilized. Because of the military equipment procurement procedures there is seldom the ready acceptance and acquisition of experimental and untested equipment by the military as prevails in universities and research centers. Having previously enjoyed the latest and newest equipment with which to work, he encounters less sophisticated and relatively obsolete tools. The new medical officer finds the physical plant austere and often poorly designed and

"jury-rigged." Frequently he must share an office with others and almost invariably there is little, if any, clerical help and other nonmedical support to which he has become accustomed. Suddenly his patients are no longer the grateful and beholding indigents but instead a rather demanding group, looking for their rightful benefits, too often showing little gratitude and always ready to put him on report to the commanding officer or favorite congressman. The pay is considerably less than that of his peers in civilian practice and for some reason he may fail to achieve the status and prestige generally extended to members of his profession. In fact, he occasionally experiences some disapproval from his line colleagues who may view medical officers as individuals who receive special privileges and considerably more pay than others of equal rank. The wife is cast into a new community and a strange new way of life which may be frightening and threatening. The available housing is less than the 14-room mansion she had dreamed of occupying when her husband became an "established practitioner." The schools may leave something to be desired. The entertainment and cultural assets of the community may be "provincial" at best and heavily accented by go-go girl bars, skin-flick drive-ins and franchise restaurants. The shops and "boutiques" are not quite comparable to Sak's or Nieman-Marcus. Many of the same conditions would have prevailed if the neophyte physician left his academic setting and entered into private practice, but he does not yet recognize this. In short, the first few months of the new medical officer's career are marred by a traumatic readjustment, all blamed on the military and requiring heroic therapy if the military career can be made attractive. The passage of time and professional maturation improve the picture somewhat. With the acclimating process comes greater job satisfaction and community identity. The "fringe benefits" begin to take on some reality. But the course is still filled with rocks and shoals in the form of frequent moves, tyrannical bosses, bureaucratic bungling, to name only a few. The threat of ever-increasing administrative duties is anticipated with repulsion. Without the advantage of a full knowledge of the nuances of civilian practice with which to compare, he is blind to the many advantages of a military career. He little realizes that he will have much more free time in spite of occasional periods of unaccompanied duty. The opportunities for family life and the pursuit of hobbies are far greater. Financial consideration for the patient is not imposed and this encourages the practice of a much purer medicine. The frequent moves do bring travel and adventure, and may become, in fact, an



excellent educational asset for a young family. The "way of life" begins to take on a definite meaning and frequently becomes attractive. Opportunities are always present for additional training without great disruption in schedule. The administrative duties are usually far less burdensome than the day-to-day details of the private office business management or those encountered in an advancing and successful civilian academic career. The opportunity for early retirement provides a substantial annuity and the chance for a whole new second career. The "fringe benefits" are real and significant. As unfashionable as patriotism may be today there is still some reward in serving the people who serve their country. With the current trend toward a government-controlled practice of medicine, the military may soon appear even more attractive to many physicians.

The medical needs at the Bureau level are not often considered by the casual observer. The first order of business is the development and establishment of physical standards considered essential for military service. To merely accept the usual criteria of health, such as is promulgated by insurance actuaries, is not adequate. Special expertise must be gained in projecting the demands of the infinite varieties of occupations employed in every conceivable condition in the military service. Such knowledge is not "standard stock" in the medical profession.

The last order of business is the physical evaluation of a member at the end of his career, the determination of any medical deterioration that is service-connected and compensable, and if so, to what degree. Again, this requires a moderate amount of special training that is in short supply.

Neither of the above jobs appears very attractive to the average physician, but these functions are of great importance from both an operational and financial standpoint.

The Surgeon General requires a large staff of professional people to advise and direct the unique medical requirements of his diversified forces. Operational experience is a prerequisite for such a staff and, although full of administrative detail, this work still must be accomplished by persons with medical degrees. Health care facility construction, procurement of equipment and supplies, evaluation of work loads and assignments of adequate and proper personnel, budgetary allotments, Congressional reports, inter- and intra-service liaison — all require medical knowledge and professional supervision.

In addition to the Bureau staff, the Medical Department's resources must be adequate to fill the operational billets mentioned above. There should be a mix

of general medical officers and specialists. They should be sufficient in number to allow for continuity of health care as well as frequent rotation in the less rewarding duty stations. Adequate assets permit necessary adjustments for refresher courses, sabbaticals for training, leave and travel times. Unexpected emergency requirements must be anticipated where type-specific physicians may be needed for variable short periods of time. The unencumbered broadly-educated generalist, knowledgeable in administrative detail, who may be counted upon to go anywhere, anytime, is the ideal prototype and is almost nonexistent.

Plans for the future include a major cutback in numbers of military physicians and greater utilization of civilian facilities. The expansion of the Physician Assistant Program is envisioned and a major shift of administrative details from physicians to Medical Service Corps officers is in progress. A small elite all-volunteer force is desired. Input from the ongoing medical scholarship programs and possibly a Federal medical academy are viewed as potential major recruitment sources. Although these measures assure a minimum of five years of obligated duty per member, the time investment is not of such significance as to guarantee a career officer in each case. Whatever additional incentives may be devised, in terms of pay and stability, may well be counterbalanced by the elimination of dependent and retired care from all facilities except at a few teaching centers. For most medical officers, the present opportunity to engage in a diverse practice is one of the major attractions.

The capability of the civilian sector in assuming total medical care of dependents and retired members is also questioned. In nearly every area military physicians are "moonlighting" at the request of local civilians to care for current patient loads. A smaller Defense Department Medical Corps offers no guarantee that the physician-patient ratio will improve in given population areas. The prospect of civilian care is not popular with a large and vocal percentage of retired personnel. Neither is cost sharing a popular concept and this is widely viewed as another broken promise of retirement benefits.

The concept of utilization of Medical Service Corps officers for command is not without problems. In the Navy certainly, there are few with both a master's degree in Hospital Administration, and sufficient experience and seniority to command. Possibly this capability can be developed but it will take time. The professional savings may be more apparent than real in the latter event, since a physician would inevitably be required as director of professional services on a full-time basis, as opposed to collateral duty arrangements



prevalent now. The commanding officer of a military hospital is not entirely analogous to an administrator of a civilian hospital. Participant management is desirable, but despite excellent available sources of advice, authoritative decisions must be made that are best made by a physician CO.

The unification of the Surgeons General offices is again being advocated. Undoubtedly some duplication of effort does exist. It is true, however, that one of the frequently voiced complaints of resigning physicians is that "No one in the Bureau took any personal interest" in career patterns or personal requests. It is not likely that bureaucratic consolidation will enhance the image of personal concern.

One certainty is that greater and more effective use can be made of physicians' aides and assistants. Hospital corpsmen should be corpsmen instead of ambulance drivers, yeomen, and masters-at-arms. The Nurse Corps should decide upon their role and identity in the health care team. Automation and computer science can be more broadly applied. All such related changes will increase the productivity of all persons including the medical officer.

Regionalization with the view toward maximum utilization of our scarce resources is a necessity. Greater mobility and flexibility responsive to changing needs must be achieved. There can be greater cross servicing of all Federal facilities without loss of control by parent commands. Duplications of manpower as well as

equipment must be eliminated. Line commanders must realize the difference between desirability and necessity and accept care responsive to actual need rather than stand-by services awaiting a possible eventuality.

However necessary, the prestige of the military physician must be raised and greater job satisfaction achieved, with equal if not greater remuneration as compared with the average civilian physician. The medical positions in the Department of Defense must be sought after, and procurement must be on a highly competitive basis.

The current unpopularity of the military is a natural and predictable phenomenon which has evolved after every war. This will improve with time. The increasing governmental intervention into all things medical will, by comparison, make military medicine more acceptable to physicians.

This paper represents an attempt to place in perspective the problems of health care delivery in the military. The needs of the Armed Forces are examined. The desires of the patients are set forth. The personal problems of the physician are explored. The problems of direction and management are reviewed.

To our misfortune we are long on questions and short on answers. But the crisis is real and demands profound wisdom and heroic treatment. It is hoped that our leaders will distinguish between the water and the wave. ☸

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#### CHANGES TO AWARDS CATEGORY OF ADVANCEMENT MULTIPLE

The Chief of Naval Personnel has announced that beginning with the August 1972 examinations, two major changes to the Awards Category of the Advancement Multiple computation schedule will be affected.

First, that Letters of Commendation awarded to personnel for noteworthy or commendable accomplishments beyond the usual requirements of duty or exceptional displays of energy, judgment or initiative but not warranting the award of a medal, will count one multiple point. Such letters must be signed by a Flag officer or by the officer next senior in command to the individual's Commanding Officer or Officer-in-Charge.

Second, that since Unit Awards are not awarded as a result of individual achievement, but rather unit achievement, that such awards will no longer be included as a part of the Awards Category.

The effective date and the specific details regarding these changes will be published in the near future by a BUPERSNOTE. The same Notice will contain the details of the PNA point award system.

The changes to the Awards Category will provide Commanding Officers with a simple, more meaningful method by which outstanding individual achievement can be recognized and enhance the development of the competitive advancement system.—NAVNEWS, Washington, D.C. ☸

# Indoctrination

and

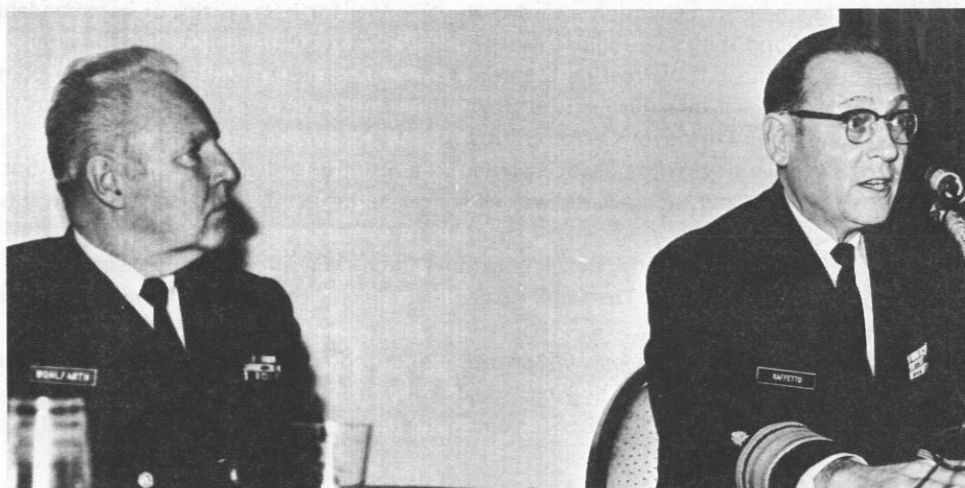
# Management Seminar

The third Indoctrination and Management Seminar for newly selected captains in the Medical Corps and Dental Corps was held at the Washington Hilton Hotel, Washington, D.C., from 27 Feb to 3 Mar 1972. Sponsored by the Bureau of Medicine and Surgery, the Seminar was presented by the Naval Medical School, the Naval School of Health Care Administration and the Naval Graduate Dental School. The purpose of the Seminar, which has earned high praise, is to formally introduce the selected officer group to the theory and practice of management at a transition point in their careers, when they can be expected to participate in the direction and control of the Navy's health care delivery system.

The program provided a broad range of useful information in professional, personnel, research, administrative, fiscal, military and legal areas. The opportunity to establish direct communication with key central personnel is one of the valuable outgrowths of the week spent at the Seminar. More effective coordination and understanding are bound to follow.

One highlight of the week was a social hour and dinner held at the Commissioned Officers' Mess (Open), NNMC, Bethesda, Md., where VADM Davis, MC, USN, Surgeon General, addressed the attendees.

We are indebted to the Photographic Division of the Medical Graphic Arts Dept., Naval Medical School, NNMC, Bethesda, Md., for excellent photographic coverage.











# CAPT LUKASH ON THE CHINA SCENE

Apparently the first Navy physician to re-enter China since 1945, CAPT William M. Lukash, MC, USN, Assistant Physician to the White House and head of the Gastroenterology Service at the Naval Hospital, NNMC, Bethesda, Md., accompanied President Nixon's party on the recent trip to the People's Republic of China. CAPT Lukash assists the President's personal physician, MAJGEN Walter R. Tkach, USAF, who also made the trip.

CAPT Lukash made some interesting medical observations during the trip. Despite the comparatively relaxed aseptic precautions in the operating rooms there, he was impressed by the lack of postoperative infections. He observed the clinical use of bretelium, a drug

to control cardiac arrhythmia which is yet restricted to experimental use in the U.S. Paramedical personnel with a minimum of medical training deliver medical services to farm workers in rural dispensaries; this approach to the medical care of 800 million citizens appeared to be appropriate and realistic. Intestinal cancer is more prevalent among the Chinese than lung cancer, and the Chinese appeared to enjoy smoking cigarettes without too much concern for the potential perils of pulmonary disease.

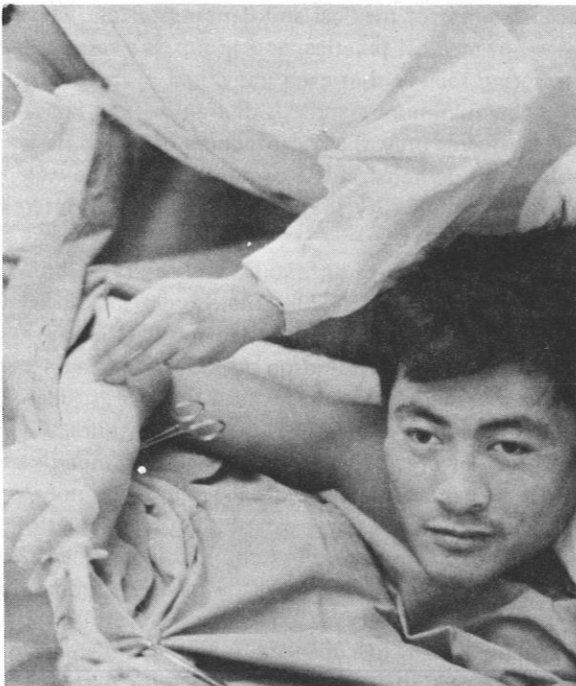
The most intriguing aspect of the medical scene was the use of acupuncture for anesthesia and treatment. Although they have inserted long needles into selected areas of the body for therapeutic benefit for several

Dental extraction was performed with the use of one acupuncture needle inserted into the right cheek.





NAVY CHIEF HOSPITAL CORPSMAN IN CHINA — HMC Robert J. Dunn, USN, stands at the Great Wall in the People's Republic of China.



Chinese patient about to undergo thoracotomy and pneumonectomy for tuberculoma. One acupuncture needle in the right forearm was kept under constant manipulation with circular up-and-down motion throughout the surgery. He remained awake and felt no pain.

thousand years, the Chinese have used the long thin needles for anesthesia only since 1959. Dr. Lukash observed many surgical procedures accomplished under acupuncture anesthesia with the patient completely awake and comfortable. Included among these cases were a number of dental extractions, a pneumonectomy, excision of an ovarian cyst, and an appendectomy. This technique deserves further exploration and CAPT Lukash has remarked that overall, he was favorably impressed with the level of medical expertise which he viewed at several hospitals in Peking.

Chief Hospital Corpsman Robert J. Dunn, USN, who is also assigned to the White House, made the advance trip to China along with the many technical support personnel. Chief Dunn did an outstanding job in caring for the ordinary medical problems encountered by this group, and he developed excellent liaison with the Chinese doctors that assisted in the more serious medical problems. HMC Dunn spent over 30 days in China and had the opportunity to work very closely with both fully-trained doctors and traditional Chinese doctors (paramedical personnel). He was commended by General Tkach and other members of the White House staff for his outstanding assistance and contributions. 🍷



# Camels or Horses: Suggestions for Improving Committees\*

By LT James D. Bentley, MSC, USNR,  
Instructor and Research Associate,  
Naval School of Health Care Administration,  
National Naval Medical Center, Bethesda, Maryland.

For a good many years sociologists specializing in the study of occupations have recognized that medical practice and dental practice possess some fairly distinctive characteristics. Various theorists have identified a variety of these special characteristics, and, while each sociologist does not accept every one of the special characteristics advanced by his colleagues, there is unanimous agreement that one of the unique characteristics of medical and dental practice is their relatively high degree of autonomy. Unlike the engineer whose efforts are evaluated by the members of another occupation — perhaps an architect — the efforts of physicians, surgeons, and dentists are primarily evaluated by other members of their own profession.

In permitting this high degree of autonomy, society has established a *quid pro quo* with the medical and dental communities; in exchange for the privilege of autonomy, society requires that the medical and dental communities assume responsibility for the quality and

appropriateness of medical and dental services. Those engaged in medical practice, as a group, are responsible for assuring society that each individual in the profession meets minimum standards of training and knowledge, performs only those procedures of which he is capable, and demonstrates a commitment to the welfare of the community that at least exceeds his interest in personal profit.

This combination of autonomy and responsibility creates a dilemma which Eliot Freidson, a sociologist with the New York University Medical Center, has carefully described.<sup>1</sup> Freidson asserts that because the decision-making required in medical practice is judgmental rather than calculative, the efficient bureaucratic form of organizing control over the standards of practice is inappropriate. Medical practice has not exercised its responsibility by establishing hierarchies of physicians to judge the efforts and accomplishments of subordinates. On the contrary, the medical community has institutionalized its responsibility in informal and formal committees of colleagues, with each member of the peer community potentially eligible for participation in the committees. Thus, there are committees on credentials, medical records, the utilization of services and drugs, and so on.

The committee system and the proliferation of

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\*This paper was originally presented at the Indoctrination and Management Seminar, Navy Medical Department, Washington, D.C., 2 March 1972.

The opinions expressed herein are those of the author and cannot be construed as reflecting the views of the Navy Department or of the naval service at large.



committees are uniquely endemic to medical and dental practice stemming from their relatively high degree of autonomy, their relatively high sense of social responsibility for the quality of practice, and the judgmental character of much of their decision-making.

### Management is the Key

Committees, as an organizational form, have certainly received their share of "bad press." Undoubtedly, everyone has heard of the unidentified sage who defined a committee as "a collection of the unfit appointed by the unwilling to perform the unnecessary." The productivity and success of committees is frequently described with the old one liner that a camel is a horse made by a committee. And lastly, the atmosphere prevailing in many committees can be summarized by a brief conversation overheard between two senior Medical Corps officers. As soon as the first officer had reminded the second that the particular committee was to convene at 1300 sharp, the second replied, "Yes sir, and it will adjourn at 1630 dull!" The committee's tarnished reputation is not limited to the hospital or clinical setting. In completing questionnaires while attending recent Harvard Business School symposia, over 75% of the 200 participating business executives reported that most meetings they attend are a waste of time, too long, disorganized, or ineffective.<sup>2</sup> Mr. Earle A. Chiles, — President of Fred Meyer, Inc., a large retailing firm headquartered in Portland, Oregon — has astutely summarized the problems of committees in the following statement:

"When poorly staffed, chaired, or handled, . . . , committees become notorious time wasters. They arrive at conclusions reluctantly, and more often than not negotiate and compromise all vitality out of an idea or proposal before agreeing to recommend or accept it. A few members often dominate a committee, so others — perhaps with valuable contributions to make — do not participate. This not only deprives the organization of their ideas, but denies these members the opportunity to benefit and learn. They therefore tend to lose interest and resent the time spent in meetings."<sup>3</sup>

In spite of these problems, Mr. Chiles does not advocate eliminating the committee structure as a form of business organization. Rather, he identifies the critical issue underlying the frequent failures of committees:

"Probably no other organizational device has been more maligned or made the butt of more jokes than committees. But the carping and ridicule are seldom focused

properly, and accordingly are seldom justified. The difficulty is that the use of committees looks deceptively simple when, in fact, it necessitates dealing with enormously complex and dynamic human relationships. . . . The problems are a function of poor management — or, more probably, of management deceived by the apparent simplicity of using committees."<sup>4</sup>

If Mr. Chiles is correct, the committee structure can be rendered a more effective and efficient organizational device if its management is improved. Let us now consider some practical suggestions for improving the management of the committees you may appoint, chair, or on which you may serve.

### Committee Management

Committee management is not a separate and unique brand of management. Rather, committee management consists of applying the five traditional functions of management in a committee setting. Committee management, like patient administration, involves planning, organizing, staffing, influencing and controlling.

#### Planning

Planning is the first function of management because it provides the foundation for all of the other management functions. In planning, objectives are identified, policies established, plans laid, and standards specified. A good first step in planning committees, whether you appoint them or work on them, is to determine and specify the purpose of the committee. A committee has the responsibility to do something as a group, and that something should be clearly established. Broadly speaking we can identify five major purposes for committees. First there are Executive Committees whose functions are to do something, to direct activities, or to take action. Second, there are Advisory Committees which offer opinions and recommend action by competent authority. Third, are Education Committees which exchange knowledge and information amongst the participants. Fourth, are those committees whose purpose is to adjust differences between operational units. These are the Coordinating Committees. Fifth, Investigation Committees are established to probe a situation or explore a problem. It is imperative that the appointing authority clearly determine, in advance, whether the committee has been appointed to execute, to advise, to educate, to coordinate, or to investigate. From personal experience, I can attest to the difficulties that arise when the purpose of a committee is not clearly established, for an advisory committee that attempts to execute action can cause severe organiza-

tional conflict and trauma.

In addition to establishing the purpose of the committee, the appointing authority should plan to communicate the purpose of the committee, and of its every meeting, to each committee member. A particular committee, or a given meeting of a committee, can mean many things to different people. Unless every original and newly appointed member is informed of the committee's purpose, participants will experience the utter frustration that is created when an advisory committee tries to coordinate or an educational committee tries to investigate.

As a final suggestion for the planning function, it is a good idea to establish advance agendas for committee meetings. First, they help to communicate the purpose of the meeting. Second, they permit every member the opportunity for background preparation. Without an agenda, members may derail the meeting simply by saying they are not prepared to discuss a given issue. Third, an agenda provides the chairman with a tool to channel discussion by restricting digression. An agenda, routed a day or a week ahead, can save many valuable man-hours.

### *Organizing*

In organizing a committee there are two elements to be considered: environmental factors and the committee's internal structure. The environmental factors which surround a committee seldom receive much attention in the United States. For example, many Americans considered the shape of the table used at Paris Peace Talks as an irrelevant issue designed to delay the start of any constructive action. In fact, the seating arrangement is simply one of a host of environmental factors that psychologists believe are responsible for 15 to 20% of the success or failure of committee meetings.<sup>5</sup>

One environmental factor is the site chosen for the committee meeting. In establishing a meeting place the chairman can select a location near everyday activities — subject to all of the everyday pressures and interruptions — or he can try to insulate the committee by removing it from his office, his service, or his building. This insulation can be overdone. Last year the Medical Corps Command and Staff Conference met at Airlie House, a beautiful estate in rural Virginia. The site did remove the participants from the pressure of everyday activities. But it so removed them that it left a rather cosmopolitan collection of attendees with a feeling of isolation, not insulation. In selecting the meeting site the chairman needs to know the committee members well enough to determine what will enhance, and what will endanger, their potential for

success.

Seating arrangement is another, perhaps more important environmental factor, for it may predetermine communication patterns. Take the case of a committee meeting held in the chairman's office. Most likely the seating arrangement will resemble a triangle with the chairman at the apex and the other members forming the triangle's base. In this arrangement, the chairman can easily dominate the group, and this is fine if that is his purpose. But, if he desires a group discussion with everyone involved, such a seating arrangement will work against him. Likewise a long conference table, with the chairman seated at one end, provides the chairman with an excellent arrangement for dominating the discussion. Movement of the chairman to one of the side corners will generally facilitate group participation. But for group discussion, nothing beats the old-fashioned circle of chairs. In the circle everyone has visual access to each of the others and no one is more centrally located than anyone else.

Meeting location, seating arrangement, room size and lighting are four environmental factors which influence the effectiveness and efficiency of committees.

The internal organization of the committee will not be directly addressed, for almost all of the previous and following points indirectly focus on this topic.

### *Staffing*

There are several background characteristics which should be considered in staffing a committee and selecting a chairman. First of all, each of the individuals should be capable of working in groups. A confirmed and dedicated "loner" may be physically present at all meetings but resists every provided opportunity to be included in the group. Likewise, anyone who abhors disagreement and debate may be an inappropriate member unless you are trying to socialize him. Second, all participants must be willing to consider other viewpoints. A committee is no place for a dogmatic doggoeder who refuses to consider anyone else's equally-sincere position. And a committee is no place for the individual who sees or frames a personal attack or vendetta in every point of disagreement. Each member must be able to weigh all viewpoints. Third, the selection of committee members must exclude those individuals who avoid disagreement and the debating of honestly-held differences by establishing a compromise at the lowest common denominator. And finally, every member selected should have a healthy measure of respect for those who disagree. Each of the committee members should embody all four of these desirable characteristics. Moreover, because most committees rely heavily on their chairman, every chairman who is

appointed should be capable of working in a group, willing to see others' viewpoints, careful to avoid the lowest common denominator, and respectful of those who disagree.

Sometimes in industry there is a tendency to appoint a committee consisting of only the most senior members of the firm. Committees in Medical Department activities should avoid this tendency. First of all, a committee of only the most senior officers will but duplicate the formal organization. In general, a committee may be viewed as an organizational device designed to overcome some limitations present in the formal organization. Consequently, the committee should only rarely duplicate the formal organization. Second, in an occupation of colleagues, committee assignments provide training and socialization opportunities for junior officers. It is for this very reason that many civilian hospitals now include interns and residents on credentials and medical audit committees.

One additional comment on staffing should be considered. Most committees, especially those having other than an educational purpose, function more effectively when a committee member serves as the recording secretary. The inclusion of a staff or personal secretary may facilitate the production of committee minutes, but it also generally inhibits conversation, especially disagreement.

### *Influencing*

The fourth management function is influencing. Many authors use the term "directing" for this function. I prefer the term influencing, for directing is only one style of influencing people. In general the influencing style selected should be chosen after considering both the purpose of the committee and the personalities present on the committees. An authoritarian style in which the chairman forcefully directs the committee may be appropriate for an executive committee charged with taking action. An authoritarian style is probably inappropriate, though, for an educational or coordinating committee where each member should be encouraged to participate. In the latter committees, a low profile by the chairman may facilitate, rather than frustrate, goal attainment.

Second, in adopting a style of influencing committee members, committee members will be most effective if they adjust their style to the characteristics of the individual members. For example,

"There are always a few at any meeting who cause problems. You probably will recognize Nonstop Norbert, Contrary Carl, Silent Sam, Fumbling Frank.

"Norbert's harmless — but he loves the sound of his voice. You can usually stop him with a tactful comment like: 'Let's get back to the topic now, but we'll pursue that excellent point later.'

"Carl's a compulsive nay-sayer. Don't argue with him. Instead, ask others to comment on Carl's views.

"Frank's inarticulate, and Sam's shy. Both may have something worthwhile to contribute. Try to draw them out — if they seem to have something to say. Then rephrase it and feed it back. There are others who may make a meeting stumble, too. But usually, courtesy, tact, patience and restraint will keep a discussion on track — and make it a success."<sup>6</sup>

In summary, every committee member must carefully fit his influencing style to the committee's purpose and its people.

### *Controlling*

In terms of controlling the committee, some type of Machiavellian manipulation is not being advocated. But the committee's achievements, or lack of achievement, should be compared with its purpose. For controlling individual meetings, the agenda established in the planning stage provides an excellent management tool. With an agenda, discussion can be continually reoriented to the topics under consideration. Digressions can be derailed and deletions can be discovered and developed. With an agenda, it is also possible to allocate committee time to specific topics. While it may seem dictatorial to regulate discussion by the clock, the presence of a time deadline may force people to present their ideas concisely so that the committee covers more ground than it would have without a deadline. As a control device, the agenda is difficult to surpass.

### **Conclusion**

Health care consumers have a vital interest in the effective management of medical activity committees, for directly or indirectly, most committees affect the quality and quantity of the health care they receive. If appointing authorities and committee members give little attention to their committees, neither the providers nor the consumer will benefit, and the committees will be subject to the usual abuse. Each officer in the Medical Department, therefore, is encouraged to apply the principles of management to his committee assign-



ments so that the committees will make horses — not camels.

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4. Ibid, pp 2-87, 2-90.

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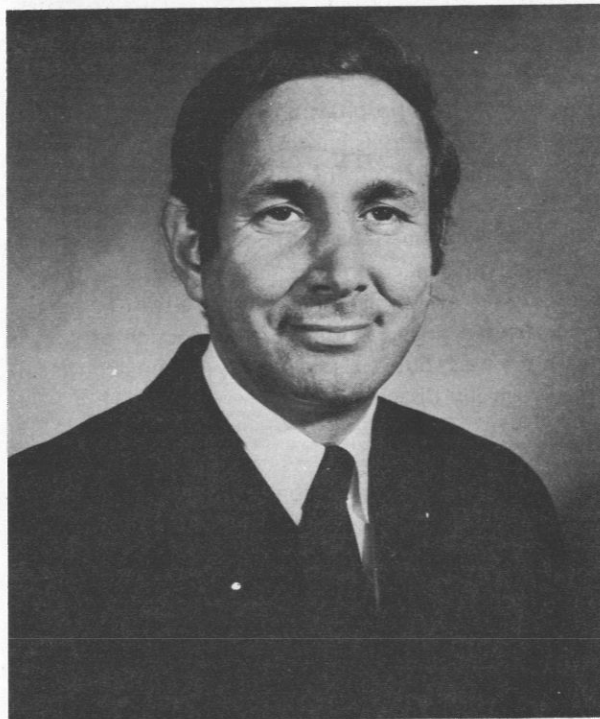
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#### CDR ANASTASI HONORED

CDR Gaspar W. Anastasi, MC, USN, Chief of Plastic Surgery at Naval Hospital Boston has received an award from the American Board of Plastic Surgeons for a professional thesis describing a new surgical procedure which he developed and evaluated over a two-year period. The surgical procedure involves replacing a section of the urethra in patients suffering from strictures or obstructions, by means of a pedical patch. Over the past two years twelve such patients have been successfully treated. Ten of the procedures were performed at the VA Hospital in Boston, and two were done at the Naval Hospital Boston. Coauthor of the paper was Dr. Carl A. Olsson, Chief of Urology at the Boston VA Hospital.

The paper was awarded third prize in the Junior Classification of the 1972 Foundations Scholarship Contest, sponsored by the American Board of Plastic Surgery. The Junior Classification includes plastic surgeons who have practiced five years or less since completing their training. This is probably the first time a military surgeon has won this award, which provides for a three-month scholarship for study and travel within three years from the date of the award.—PAO, Nav Hosp Boston, Chelsea, Mass.



CDR Gaspar W. Anastasi, MC, USN 🍀

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#### WAVE PSYCHOLOGIST

The Navy now has a woman psychologist.

LT(j.g.) Carmen E. Slate is currently the only woman psychologist serving in the Medical Service Corps.

Miss Slate is currently receiving eight weeks of training at the Bethesda Naval Hospital, after which she will report to the Naval Hospital, Oakland, Calif.—NAVNEWS, Bethesda, Md. 🍀





*To the Editor:* Would it be possible to picture a Russian ship to compare with the seemingly old U.S. ships you show?

J.A. Anderson, M.D.  
The Madison Clinic  
Madison, S. Dak.

*We've put out a call for Russian ships. — Ed.*

*To the Editor:* I would like to submit the following for consideration by those of our Navy physicians who object to being regarded as naval officers:

"It is by no means enough that an officer of the Navy should be a capable mariner. He must be that, of course, but also a great deal more. He should be, as well, a gentleman of liberal education, refined manners, punctilious courtesy and the nicest sense of personal honor.

"He should be the soul of tact, patience, firmness and charity. No meritorious act of a subordinate should escape his attention or be left to pass without its reward, even if the reward is only a word of approval. Conversely, he should not be blind to a single fault in any subordinate though, at the same time, he should be quick and unfailing to distinguish error from malice, thoughtlessness from incompetency and well-meant shortcoming from heedless or stupid blunder."

From the letters of John Paul Jones

Substitute the word physician for mariner in the above paragraph, and you have described a standard of professionalism and decorum to which we should all aspire. The same professionalism which ought to be developed to the highest degree in a mature physician should make the transition to officer status effortless.

CDR William M. McDermott, Jr., MC, USN  
NavHosp, Portsmouth, Va.

*To the Editor:* The continuing discussion in this section concerning the status of Medical Corps officers (Officer first, M.D. second) has been closely followed by myself and many other Medical Service Corps offi-

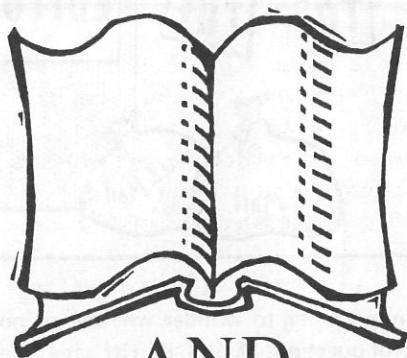
cers. I am beginning to wonder whether or not this is a meaningful question. As LT Barritt says, (Letters to the Editor, Vol. 59, Mar 1972) perhaps there is a directive setting down the status, but does it really make any difference? Rather, is this whole discussion indicative of the polarization that has existed for quite a while between the Medical Corps and the rest of the Navy? I think it is. This polarization, whose existence is fostered equally by both groups, is working directly against the primary mission of the Medical Department. Both groups, working against each other, are accomplishing almost nothing. The only group to suffer directly is the patient population in areas where this is occurring. If there is any doubt concerning this, question dependents and patients where such polarization is an open fact. When you find service personnel taking their dependents to civilian physicians, and they live within ten miles of a naval hospital, certainly something is wrong.

In light of the deleterious effects of polarization, the argument which caused it fades into insignificance. Who cares what you call yourself when the system is failing? Perhaps the best cure for the polarization is a movement toward the center. Each group can attempt to communicate with the other, and explain their abilities, limitations, and problems. Understanding of the other fellow's position won't solve all the problems, but it is a start. This has been attempted on a small scale at this activity. The results, even at this primitive stage, are gratifying. It is expected that the benefits resulting from this interchange will expand as the program develops.

Let's face it, the patient treatment system is not the same as a circular universe in which two points, moving away from each other, will eventually merge. In the Medical Department, two groups moving away from each other will only move farther apart.

LTJG Floyd J. Dunaway, MSC, USN  
NavHosp, Key West, Fla. ☐

# ABSTRACTS



## AND REVIEWS

**Sjogren's Syndrome**, by Martin A. Shearn, M.D., 262 pp, \$11.50, Philadelphia, W.B. Saunders Co., 1971.

This book is the second in Saunders' series, "Major Problems in Internal Medicine." It is a comprehensive and exhaustive monograph which covers the historical aspects, pathological involvement, diagnostic techniques, clinical features, associations with connective tissue and malignant diseases, laboratory findings, prognosis and therapy. There is also a fascinating chapter on pathogenesis in which the roles of auto-immunity, genetics, and infectious agents are considered. The normal as well as abnormal histology of the salivary glands are presented, along with a discussion by text and illustration of the physiology of lacrimation.

This well-referenced (579) and authoritative volume is a must for those interested in more than the skeletonized account of this interesting entity which is found in most standard texts.

LCDR Stephen A. Grzenda, MC, USN  
Naval Hospital, NNMCMC, Bethesda, Md.

**Peripheral Vascular Disease**, The Cardiovascular Clinic Series, \$10.00, Philadelphia, F.A. Davis Co., 1971.

This book reviews a subject long represented in the contents of established textbooks, touching on the newer aspects of the problems as well.

A wide spectrum of clinical disorders is discussed under separate chapters, each edited individually by an impressive list of well-known specialists in the field. From the natural history of arteriosclerosis obliterans,

one is directed through aneurysms involving the major arteries, to sudden occlusive diseases. Hypercoagulability, as well as clinical considerations of venous and lymphatic diseases are presented. Medical and surgical modes of therapy are discussed. The topics are easy to read, follow a natural trend in continuity, and are well referenced.

I found specific chapters dealing with dissecting aortic aneurysms to be quite complete with very definite emphasis on the newer concepts of medical management. The two chapters dealing with sudden arterial occlusion were very good. A discussion of etiology, physical signs, arteriograms and venograms clearly demonstrating the anatomy, as well as medical management and surgical approaches characterized the section. The section on arteriospastic disease and the chapter on inflammatory disease were brief but concise and their strength lies in the clarity they afford by their classification of the disease processes.

The multiplicity of authors, well versed in their subject matter, has afforded the clarity and brevity so necessary for a good review with substantial references for further research and reading as the individual chooses. The pictures are clear, the graphs and charts easy to visualize, and the cost reasonable for this authoritative review of peripheral vascular disorders.

LCDR Hugh Bernard McCormick, MC, USN  
Naval Hospital, NNMCMC, Bethesda, Md.

**Diverticular Disease of the Colon (M.P.C.S. XI)**, by Bentley P. Colcock, M.D., 1st ed., 135 pp, \$9.00, Philadelphia, W.B. Saunders Co., Aug 1971.

This is the first edition of Volume XI in the series, "Major Problems in Clinical Surgery." The force of this volume is aimed primarily at the surgeon; however, it has considerable value for the internist, gastroenterologist, and the family physician.

The author has arranged an extremely difficult and controversial subject into a very readable and organized volume presenting the current status of diverticular disease of the colon. He has generously used diagrams and photographs of pertinent roentgenograms of excellent quality to illustrate the various themes of the text. He has interspersed much of his personal experience and prejudice, as he freely admits, in the management of diverticular disease of the colon but he has not failed, in the least, to give the views and results of many other competent surgeons. The bibliography should be of great value to anyone reviewing the subject.

The volume is highly recommended for the library

U.S. Navy Medicine

not only of the surgeon but of all physicians who have to deal with the abdominal complaints of patients.

CDR Ronald D. Gaskins, MC, USN  
Naval Hospital, NNMCMC, Bethesda, Md.

**Critical Surgical Illness**, edited by James D. Hardy, M.D., 1st ed., 679 pp, 206 illus., \$28.00, Philadelphia, W.B. Saunders Co., 1971.

Steady progress in postoperative and posttraumatic surgical care has extended the surgeon's ability to save the critically ill patient. Covering disorders which account for the greatest mortality in surgical centers caring for the seriously ill, the following situations are considered: posttraumatic pulmonary insufficiency, shock, water and electrolyte imbalance, abdominal and thoracic trauma, wound sepsis and dehiscence, massive burns, pulmonary embolism, intra-abdominal sepsis, massive gastrointestinal hemorrhage, infected arterial grafts, pulmonary sepsis, and complications of radical neck dissection. These represent a partial list of the complex clinical situations which are approached in a manner that emphasizes underlying pathophysiology as well as technical considerations.

A brief biographical sketch of each contributor begins each chapter. Each section is followed by a bibliography which strikes a balance between completeness and brevity.

While the dispensary-based physician and general medical officer would probably have little use for this book, those dealing with the seriously and often chronically ill surgical patient will find it indispensable in acquiring knowledge required for the "moral acceptance of total responsibility for the patient's welfare."

LT Charles C. Haynie, MC, USN  
Naval Hospital, NNMCMC, Bethesda, Md.

**Medical Parasitology**, by Edward K. Markell, Ph.D., M.D. and Marietta Voge, M.A., Ph.D. 3rd ed., 357 pp, 141 illus., \$13.75, Philadelphia, W.B. Saunders Co., 1971.

The authors have abandoned the former arrangement of their text by organ systems and have gone to a taxonomic presentation in this third edition. Those disturbed by this change in format will find that the chapter on signs and symptoms of parasitic disease

helps to make a smooth transition. The adjustment for the clinician familiar with the first two editions will be minor and the change is refreshing. It renders the text more versatile and usable by clinician, student and technician.

The book has a useful index. It is referenced at the end of each chapter for those interested in more detailed study of the subject. Though the references were current at the time of the text's revision, they are now somewhat dated. The material is concisely written and well illustrated. For each disease there is a description of the parasite involved followed by a discussion of symptomatology, pathogenesis, epidemiology and treatment. The therapeutic discussions are current. There are many more X-rays, pictures of patients and cardiograms than were found in previous editions.

The illustrations of morphology of the parasites are excellent. The diagrammatic representations of the life cycles of trematodes, cestodes and nematodes are easy to understand. Summaries of morphologic characteristics of the lumen-dwelling protozoa make the task of identifying them correctly less ominous, especially for the neophyte. There are also sections in the book which deal with procedures, stains, fixatives and culture methods.

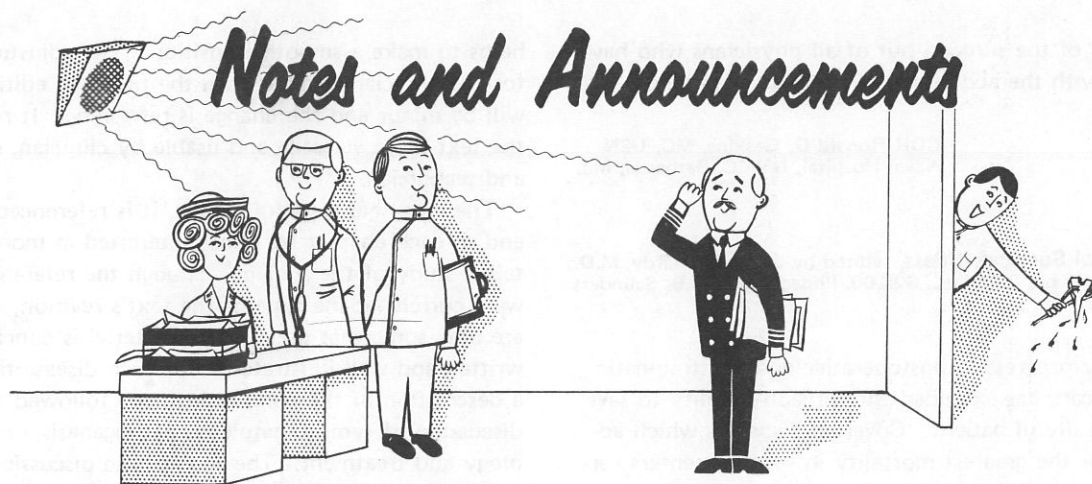
This book has something for everybody interested in parasitology but will probably be too superficial for the specialist in Tropical Medicine or Parasitology. I would suggest that every dispensary and hospital in the Navy would profit from having a copy of MEDICAL PARASITOLOGY in their library.

LT Larry V. Staker, MC, USN  
Naval Hospital, NNMCMC, Bethesda, Md.

**Baby's First Six Years**, by Barbara Shook Hazan in cooperation with RADM Robert E. Switzer, MC, USNR, and J. Cotter Hirschberg, M.D. 56 pp, \$4.95, New York, Western Publishing Co., Inc., 1972.

This book contains Notes on Growth and Development to guide parents through the formative years, and offers a means of recording the child's first six years of life in Health Record fashion. The publisher suggests it is the ideal gift for every parent, in which cherished memorabilia, important facts, and personal observations about a child's first years may be preserved. 📖





## DEGREE PROGRAM FOR X-RAY TECHS

The U.S. Navy and The George Washington University are joining ranks to expand the educational opportunities in radiologic sciences and other allied health fields for military and civilian personnel. A memorandum of agreement signed at GW by Navy and University officials launches a major academic program leading to an Associate in Science degree. It will be the first comprehensive program in the medical sciences designed to help meet some of the unusual needs of the Navy.

The School of Medicine will award the Associate in Science (X-ray Technology) to candidates meeting the requirements for the 61-semester hour course, beginning in May. The curriculum will be offered at three Navy hospitals: at Bethesda, Md.; San Diego, Calif.; and Portsmouth, Va.

The Navy agreement makes it possible for enlisted personnel to earn academic degrees in the allied health sciences as an educational fringe benefit since the student fees, books, materials and instruction are contracted by fiscal arrangement with the Bureau of Medicine and Surgery and the University.


Augmenting existing technology courses offered by Navy schools, the GW University off campus courses will be taught by accredited faculty of the School of Medicine and the courses will be administered by the College of General Studies. Under the agreement the medical faculty will also assist BUMED in assessing and correlating all medical training programs of the Bureau.

The Associate in Science degree program for X-ray technicians is the first of about 30 medical technical specialties under consideration. These include:

nuclear or cardiopulmonary medicine, nuclear submarine medicine, radioactive isotopes, electrocardiography, electroencephalography, or aerospace physiology. Still others may cover basic hospital corpsmen, clinical laboratory, medical technology or preventive medicine technicians. Additional fields involve medical photography, pharmacy, operating room or surgical specialties, and deep sea diving medical technicians. In each, personnel would undertake approved course work that can be applied toward degree requirements.

Of the initial program's 61 hours, 49 are designated in the area of concentration, X-ray technology. The remaining 12 credit hours are in communications, social sciences and humanities. An overall grade average of 2 with a 2.5 average in the area of concentration is required for the degree. (University grade averages are based on a 4-point scale.)

Dr. S. David Rockoff, Professor and Chairman of the Department of Radiology at GW, and CDR C.J. Pearce, MSC, USN, Curriculum Director, Naval Medical School, National Naval Medical Center, were instrumental in planning the curriculum and instructional base for the X-ray technicians program, along with Mr. Earl J. Ross, Director of Plans and Programs of the College of General Studies at the University.

Ordinarily the 61-semester hour X-ray technology program will take 15 months to complete. CDR C.J. Pearce explained that this would include six months of academic work and six months of clinical experience in the specialty, as well as 12 semester hours of communications, social studies and humanities. 



## CHANGE OF COMMAND

RADM Willard P. Arentzen, MC, USN, has relieved RADM Joseph L. Yon, MC, USN, as Director/Commanding Officer of the Naval Regional Medical Center, Portsmouth, and the Naval Hospital, Portsmouth, Va. Admiral Arentzen also assumed duties as Fifth Naval District Medical Officer.

VADM G.M. Davis, Surgeon General of the Navy, gave the principal address in a change of command ceremony held at the Naval Hospital on 31 March. He also presented the Navy's Distinguished Service Medal to Admiral Yon who has been instrumental in developing a new regional medical delivery system for the Navy.

The ceremony marked the end of a distinguished Navy medical career for Admiral Yon which began on 2 August 1938 when he received his commission and was assigned to the U.S. Naval Hospital, Newport, R.I. He had been Commanding Officer of the Naval Hospital, Portsmouth, and Fifth Naval District Medical Officer since 30 November 1964. On 1 July 1971 he became the first Director/Commanding Officer of the Naval Regional Medical Center when that organization was established.

In between his first assignment at Newport and his retirement, Admiral Yon held a series of progressively more responsible assignments including command of

the Naval Hospitals at Newport, R.I. and St. Albans, N.Y. He is a native of Coraopolis, Pa., received his M.D. degree from the University of Virginia School of Medicine and served an internship at St. Francis Hospital, Pittsburgh. His surgical residency was completed at Northwestern University and Cook County Hospital, Chicago, and the U.S. Naval Hospital, Philadelphia.

Admiral Arentzen, a native of Stratford, N.J., graduated from Temple University and earned his M.D. degree from Hahnemann Medical College, Philadelphia. He was commissioned in 1946 and interned at the Navy Hospital, Chelsea, Mass. Like Admiral Yon, he held a series of progressively more responsible positions including command of the Naval Hospital in the USS SANCTUARY for which he was awarded the Legion of Merit. He subsequently assumed command of the Naval Hospital, Camp Lejeune, N.C., his last assignment before becoming Deputy Director of the Naval Regional Medical Center on 1 July 1971.

The Naval Hospital, Portsmouth, is the Navy's oldest and second largest inpatient care facility. It provides general clinical and hospitalization services for active duty Navy and Marine Corps personnel, active duty members of other armed services, dependents of active duty personnel, retired members of the armed forces and their dependents.

Establishment of the Naval Regional Medical Center marked the first time in Navy history that the majority of shore-based outpatient medical facilities in a geographic area have been placed under the command of a single medically oriented Director/Commanding Officer. Sixteen medical facilities are involved.—PAO, Naval Regional Medical Center, Portsmouth, Va. 🇺🇸

## NOMINATIONS FOR AMSUS AWARDS

The Association of Military Surgeons of the U.S. will hold its Annual Convention on 10-13 Dec 1972 at the Convention Center in San Antonio, Tex. Nominations for the various awards must be submitted no later than 31 May to the Professional Division of BUMED (Code 31) which will forward same to the Chairman of the Awards Committee.

An original and four copies of each nomination are requested. Your assistance is requested in recommending eligible Navy candidates. Submit names together with a citation/summary of each individual's qualifications that justify consideration by the awards committee. A curriculum vitae on each nominee is also needed. To assist you in selecting the particular award for which your candidate might best qualify, the following list of available honors is provided.



PRINCIPALS IN CHANGE OF COMMAND — VADM G.M. Davis (center), Surgeon General of the Navy, delivered the main address during a change of command ceremony on 31 March during which RADM Willard P. Arentzen (left) relieved RADM Joseph L. Yon as Director/Commanding Officer of the Naval Regional Medical Center and Commanding Officer of the Naval Hospital, Portsmouth, Va. The ceremony also marked the end of a distinguished Navy medical career for Admiral Yon who retired from active duty.

**JOHN SHAW BILLINGS AWARD** — a plaque and an honorarium of \$500.

In memory of LTCOL John Shaw Billings whose contributions to Executive Medicine and to medical literature culminated in the founding of the Index Catalogue. Established by the Association in 1962, this award is given annually to a member of the Association under 41 years of age, who possesses and demonstrates outstanding potential in the field of Executive Medicine.

**JOEL T. BOONE AWARD** — a bronze plaque and Life Membership in AMSUS.

Established in 1969 by action of the Executive Council of the Association of Military Surgeons as a tribute to VADM Joel T. Boone, MC, USN (Ret.), who is one of the most decorated medical officers in our history. It is presented annually for outstanding contributions to military medicine and for meritorious services to the Association.

**CASIMIR FUNK AWARD** — a scroll and an honorarium of \$500.

Honors the memory of Dr. Casimir Funk, the discoverer of vitamins. He also did notable work in diabetes. This award was established by the Association in 1968 and is presented annually to a person eligible for membership in the Association, for significant contributions in the field of cardiovascular disease.

**ANDREW CRAIGIE AWARD** — a silver plaque and an honorarium of \$500.

Honors the memory of Andrew Craigie, first Apothecary General of the military forces of the U.S., who served under General George Washington during the Revolutionary War. It is presented by the Association for outstanding accomplishment in the advancement of professional pharmacy within the Federal government. It was established in 1949.

#### **FEDERAL NURSING SERVICE AWARD**

This award is given to a nurse member in one of the Federal Medical Services for outstanding accomplishments in the advancement of professional nursing. An original essay must be submitted for competition in accordance with announcements appearing regularly in *MILITARY MEDICINE*, the official Journal of the Association.

**FOUNDER'S MEDAL** — the medal, a scroll and Life Membership in AMSUS.

Authorized by the Executive Council of the Association in 1941 to commemorate the 50th Anniversary of the founding of the Association. The Founder's Medal is given for outstanding contribution to military medicine and for meritorious service to the Association.

**GORGAS MEDAL** — a silver medal, a scroll, and an honorarium of \$500.

Established in 1942 by the Association in memory of MAJGEN William Crawford Gorgas whose work in preventive medicine made possible the construction of the Panama Canal, and it is presented annually to a member of the

Association for distinguished work in preventive medicine.

**PHILIP HENCH AWARD** — a bronze plaque and an honorarium of \$1000.

Honors the memory of Dr. Philip S. Hench, a member of the Association himself, who first used cortisone in the treatment of arthritis. The award was established in 1966, and is presented to a physician in the Federal Medical Services who has made outstanding contributions in the field of rheumatology and arthritis.

**COLONEL PETER M. MARGETIS AWARD** — a plaque and an honorarium of \$500.

Honors the memory of COL Peter M. Margetis, who was an officer of the Army Dental Corps and widely renowned in the field of dental material. He was formerly the Director, U.S. Army Medical Biomechanical Research Laboratory, Walter Reed Army Research, Walter Reed Army Medical Center from 1968 until his death on June 17, 1969. Newly established in 1970, this award is presented to a member of one of the five Federal Medical Services, for outstanding contributions in the field of dentistry.

**MC LESTER AWARD** — a bronze plaque and an honorarium of \$500.

Honors the memory of COL James Somerville McLester, MC, USAR, of Birmingham, Ala., who was consultant to the Surgeon of the American Expeditionary Forces in World War I. It is presented to a member who is, or has been at any time a commissioned officer, or of relative status in the Federal Medical Services, and who has performed outstanding work in the field of nutrition and dietetics.

**FEDERAL MEDICAL SERVICES RESIDENT'S AWARD** — a scroll and an honorarium of \$500.

Established by the Association in 1970, to be presented to a Federal Medical Resident, at any level in the Federal Medical Services, for outstanding performance as a resident.

**CARL A. SCHLACK AWARD** — a bronze plaque and an honorarium of \$500.

In honor of the late CAPT Carl A. Schlack, DC, USN (Ret.), whose accomplishments initiated and firmly established dental research in the Navy. As an educator and researcher, his contributions significantly enhanced the stature of the dental profession. Newly established in 1971, this award will be presented annually by the Association to a Federal dentist of one of the five Federal Medical Services for outstanding contributions in dental education or dental research.

**STITT AWARD** — a bronze plaque, an honorarium of \$500 and Life Membership in AMSUS.

Honors the memory of RADM Edward Rhodes Stitt, a Surgeon General of the Navy who made outstanding contributions to tropical medicine. The award was established in 1954 and is presented to a member of the Association for some notable work in medicine.

**SUSTAINING MEMBERSHIP LECTURE AWARD** — a scroll and an honorarium of \$500.

Established in 1958 and is presented annually by the Association to an individual Association member in one of the Federal Medical Services who has made some outstanding contribution in the field of medical research.

**SIR HENRY WELLCOME MEDAL AND PRIZE** — a silver medal, a scroll, and an honorarium of \$500.

Established by Sir Henry Wellcome in 1916 and is awarded annually by the Association of Military Surgeons. The award is sponsored by the Trustees of the will of the late Sir Henry Wellcome for the best essay on the subject of the author's choosing which relates to military medicine.

**JAMES CLARKE WHITE AWARD** — a bronze plaque and an honorarium of \$500.

Honors a pioneer in the field of clinical and research dermatology, Dr. James Clarke White, who as an author and teacher of dermatology at Harvard, advanced the knowledge of this specialty. The award is presented to a member of the Association who has done outstanding work in clinical or research dermatology while employed by the U.S. Government.

**MAJOR GARY WRATTEN AWARD** — a bronze plaque and an honorarium of \$500.

Established by the Association in 1967 to honor the memory of MAJ Gary Wratten, MC, USA, who died while testing the Medical Unit Self-Contained Transportable (MUST) hospital equipment under operational conditions in Vietnam. It is presented for outstanding accomplishments in the field of military medicine to an individual eligible for membership in the Association. 🌿

## DR. HOOGSTRAAL HONORED

In recent ceremonies, the Honorable Robert A. Frosch, Assistant Secretary of the Navy for Research and Development presented the Conrad Award to Dr. Harry Hoogstraal, head of the Medical Zoology Department of the U.S. Naval Medical Research Unit No. 3 (NAMRU-3). The Unit, located in Cairo, UAR, is a research facility of the Navy's Bureau of Medicine and Surgery concerned with investigations on infectious diseases endemic to the Middle East and Africa.

The Conrad Award, the highest Navy award for scientific achievement, is given annually to an individual who has made an outstanding contribution in the field of research and development for the Department of the Navy. It was established in 1957 by the Secretary of the Navy in honor of Navy Captain Robert D. Conrad who was the first Director of Research for the Office of Naval Research and one of the primary architects of the Navy's basic research program. Dr. Hoogstraal was given the award in recognition of his contributions to naval medical research in the field of insect-borne diseases, especially tick-borne diseases.

Dr. Hoogstraal established the Medical Zoology Department of NAMRU-3 in 1950 and has served as its head ever since. During his more than 20 years of work there, he established a reputation as the foremost authority in the world on ticks and tick-borne diseases. Some of his most recent accomplishments include the following:

1. *Epidemiologic Pattern and Transmission Factors of Kala Azar in the Sudan.* This study has delineated the epidemiology of kala azar in the Sudan in such a fashion that previous empirical observations are now explained in terms of known cause and effect. Similarly, the bases for certain transmission factors have been explained by careful studies of vector anatomy and behavior.

2. *Studies of the Role Migratory Birds Play in Disease Transmission.* Birds migrating between the continents of Europe, Asia and Africa have been studied in conjunction with the Smithsonian Institution. These birds and their ectoparasites have been found to carry several serious viral and protozoal agents that are known to cause disease in Europe and Asia, but generally have not been detected in Africa. As a result of this study, governments of the U.S. and African nations have been alerted that these disease agents exist in Africa. This information will assist both governments and international health and agriculture organizations with detection of economically important human and animal diseases in developing nations, where little or nothing is known of the actual etiology for much human suffering and animal wastage.

3. *Isolation and Identification of "New" Arthropod-Borne Viruses.* Several previously unknown tick-borne viruses have been isolated and identified as "new." These have quickly been shown to have widespread distribution around the world. Several have been incriminated in serious previously-known but unexplained diseases.

4. *Tick Biochemistry.* Current studies of the physiologic chemistry of ticks have yielded a great deal of information. This information will be used in the near future in establishing tissue cultures from ticks in cooperation with the Rocky Mountain Laboratory. Such tick cultures will allow evaluation of epidemiologic and transmission factors of disease at the vector cellular level and provide ideal media for the isolation of more new arthropod-borne viruses.

Other accomplishments include disease vector mapping which provides information on the geographical distribution of arthropod disease vectors; a bibliography of ticks and tick-borne diseases; as well as a redescription of HAEMPHYSELUS genus of ticks including species from all parts of the world.—Code 717, BUMED. 🌿



## ASSISTANT SECNAV ADDRESSES SEMINAR

On 14 Mar 1972, the Honorable James E. Johnson, Assistant Secretary of the Navy (Manpower and Reserve Affairs) delivered the principal address at the annual Naval Reserve Dental Indoctrination and Orientation Seminar held in BUMED. The theme of the presentation was "The Challenge of the Seventies — The Naval



The Honorable James E. Johnson, Assistant Secretary of the Navy (Manpower and Reserve Affairs).

Reserve Officer's Role in Community Relations." The 29 Ready Reserve dental officers who attended the Seminar were commanding officers, executive officers or members of Naval Reserve Dental Companies, or dental officers attached to the Training and Support Component of the Naval Reserve.



Seated at the annual Naval Reserve Dental Indoctrination and Orientation Seminar are, from left to right: CAPT William J. Hepfinger, USNR, Special Assistant for Reserve Affairs, Office of the Assistant Secretary of the Navy (Manpower and Reserve Affairs); the Honorable James E. Johnson; and RADM Edward C. Raffetto, DC, USN, Assistant Chief of the Bureau of Medicine and Surgery for Dentistry and Chief of the Dental Division.

## AMA ANNUAL CONVENTION

Seven postgraduate courses will be offered at the American Medical Association's 121st Annual Convention in San Francisco, 18-22 June 1972. It marks the first time that postgraduate courses have been included on an annual convention program. They previously have been presented only at AMA clinical conventions. AMA's Council on Scientific Assembly has arranged for the additional courses because of the increasing demand for formal continuing education programs. Courses will be offered on: Acute Respiratory Failure, Anorectal Disease, Antibiotics, Common Dermatoses, Experiential Learning, Hand Surgery, and Liver Disease.

Registration fee is \$25. All registrants will receive a syllabus for subsequent home study review. They also will be eligible to obtain hour-for-hour credit toward AMA's Physician's Recognition Award in Category 4 (Continuing Medical Education Courses). The Program for the 121st Annual Convention to be held

on June 18-22 was published in the 24 April 1972 issue of JAMA.

During the Annual Convention, the Section on Military Medicine of the AMA will conduct a splendid program which all members of the U.S. Navy Medical Dept. are urged to attend. CAPT Roger Stevenson, MC, USN, Chairman of the Section on Military Medicine, will open the session at 1330 on 20 June 1972. Other highlights of the program include the free-standing session with one part presenting several individual papers and another part conducting a panel on "Coronary Disease in the Young," at 1330-1700 on 20 June. A joint session with General Surgery and Anesthesia on "Emergency Medicine and Resuscitation," at 1400-1700 on 21 June, promises to be very worthwhile.

Joint sessions with Orthopedics on "The Painful Neck and Shoulder," at 1400-1700 on 19 June, and



with General Surgery on "Surgical Infections" at 0900-1200 on 20 June, are also scheduled.

Other members of the military will present papers at various specialty sections. The following Navy participants are among these physicians:

LCDR C.J. Pepine, MC, USN — "The Latent or Asymptomatic Phase of Coronary Disease with Emphasis on Risk Factors."

CAPT M. Mills, MC, USN — "Problems with Respirators."

It is clear from the program (not yet complete) that a concerted effort to upgrade the type of presentations offered by the Section on Military Medicine has truly been successful.

See you there? ☘

## ACHA AFFILIATION

The American College of Hospital Administrators was founded in 1933 to improve and promote the practice of hospital and health care administration. As a professional organization, the ACHA has five primary objectives:

To elevate the standard of hospital administration;

To establish a standard of competence for hospital administration;

To develop and promote standards of education and training for hospital administrators;

To educate hospital trustees and the public to understand that the practice of hospital administration calls for special training and experience;

To provide a method for conferring Fellowships in hospital administration on those who have done or are doing noteworthy service in the field of hospital administration.

From an original group of 18 administrators, the ACHA has grown until, at the present time, more than 9,000 hospital and health care administrators are affiliated with the ACHA.

The American College of Hospital Administrators has four categories of affiliation: Nominees, Members, Fellows, and Honorary Fellows. The following outline gives the requirements for admission to Nomineeship and the requirements for advancement to both Membership and Fellowship. This outline is drawn from the ACHA pamphlet "Regulations Governing Admissions and Advancements." For a copy of the pamphlet, for admission and advancement forms, and for further information on affiliation with the ACHA, readers are requested to write Mr. W.R. Kirk, Director of Membership, American College of Hospital Administrators, 840 Lake Shore Drive, Chicago, Ill. 60611.

**NOMINEESHIP:** To be eligible for Nomineeship in the ACHA, the applicant must fulfill the following criteria:

**A. Graduates of Accredited Programs in Hospital Administration.** An applicant who has earned a graduate degree from a program accredited by the Accrediting Commission on Graduate Education for Hospital Administration may qualify if:

1. **Position.** He is engaged in a responsible administrative position\* in an acceptable hospital or a group of acceptable hospitals, or a related health activity influencing the operations, growth, and development of hospitals or other acceptable health-care services and programs; and

2. **Experience.** He has at least one year of experience in a hospital, either as administrative resident or in a responsible administrative position;

3. **Other.** Provided the candidate in other respects meets the eligibility requirements prescribed by the College.

**B. Graduates Holding a Degree Other Than From Accredited Programs.** An applicant who has not earned the master's degree in hospital administration but has an acceptable baccalaureate degree may qualify if:

1. **Position.** He is engaged in a responsible administrative position\* in an approved hospital or a group of approved hospitals;

2. **Experience.** He has had at least three years of successful experience in such a position;

3. **Intention.** He declares his intention to continue in the field of health-care administration; and

4. In all other respects meets the requirements prescribed by the College.

**C. Faculty.** A candidate who has a full-time appointment on the faculty of an accredited graduate program in hospital administration has the same eligibility as a person engaged in the actual practice of hospital administration, if he:

1. **Degree.** Has earned a graduate degree from a program accredited by the Accrediting Commission on Graduate Education for Hospital Administration;

2. **Experience.** Has had at least three years of experience in responsible administrative positions in a hospital;

3. **Other.** If he meets fully all the other requirements of the Council of Regents for such candidates.

\*By arrangements with the Membership Committee, the Bureau of Medicine and Surgery advises the ACHA concerning "a responsible administrative position" in the Navy Medical Department.

**MEMBERSHIP:** To be eligible for Membership in the ACHA, the applicant must fulfill the following criteria:

A. have been a Nominee in good standing for at least three years;

B. be the chief administrative officer or assistant administrative officer of an acceptable hospital, or a group of hospitals; or

C. hold a position of equal responsibility\* in an acceptable hospital administrative activity or a related health activity influencing the operations, growth, and development of hospitals or other acceptable health-care services and programs;

D. have completed satisfactorily the written and oral Membership Examinations.

**FELLOWSHIP:** To be eligible for Fellowship in the

\*By arrangements with the Membership Committee, the Bureau of Medicine and Surgery advises the ACHA concerning "a responsible administrative position" in the Navy Medical Department.

ACHA, the applicant must fulfill the following criteria:

A. have been a member in good standing at least six years, and

B. be the chief administrative officer or assistant administrative officer of an acceptable hospital, or a group of hospitals; or

C. hold a position of equal responsibility\* in an acceptable hospital administrative activity or a related health activity influencing the operations, growth, and development of hospitals or other acceptable health-care services and programs;

D. complete an approved Fellowship project consisting of a dissertation; or four case study reports; or, if the applicant attained membership at or before the 1970 Convocation of the ACHS, four single-author articles published by the applicant which are acceptable to the Committee on Credentials.

**ANNUAL DUES:** The 1972 ACHA dues schedule for Nominees is \$75.00 and for Membership and Fellowship is \$115.00. ☸

#### ACCOLADES FOR LT W.F. PETTIT

LT William F. Pettit, Jr., MC, USN received the Navy Surgeon General's Award for leadership and scholastic achievement at graduation ceremonies of Student Flight Surgeon Class 72-1 held on 30 Mar 1972 at Pensacola.

Outstanding in the class of 58 flight surgeons, Dr. Pettit is 29-years-old and received his M.D. degree from the University of Illinois.—PAO, Naval Aerospace Medical Center, Pensacola, Fla.



Dr. Pettit, outstanding flight surgeon (left), receives the Surgeon General's Award and congratulations from RADM Oscar Gray, Jr., MC, USN, CO Naval Aerospace Medical Center, Pensacola, Fla. ☸

## OFFICIAL INSTRUCTIONS AND DIRECTIVES

### MANUAL OF THE MEDICAL DEPARTMENT

#### *Change 71 of 27 Dec 71*

1. This change:

a. Combines into Chap. 1 material formerly in Chap. 3 and 6 on private practice and civil actions, and revises policy regarding private practice by Dental Corps officers, during off-duty hours; also includes the articles on Geneva Convention from Chap. 3.

b. Combines Chap. 2, 3, 4, and 5 into an updated Chap. 2, Medical Corps, along with duties relating to flight surgeons and submarine medical officers, formerly in Chap. 14.

c. Amplifies (Art. 2-22) Compulsory Medical or Surgical Treatment.

d. Updates Chap. 6, Sec. II on organization of the Dental Division, and incorporates the provisions of SECNAVINST 6320.8D as they apply to dental care for eligible dependents, and for retention of panoramic radiographs.

e. Provides a revised Chap. 8, Nurse Corps.

f. Revises Chap. 10, updating the sections on civilian employees and positions, and incorporates section on civilian physicians from Chap. 5.

g. Removes from Chap. 14 the section on FMF medical support which is incorporated into a new Chap. 19, Fleet Marine Force.

h. Deletes [Art. 21-2(5)], the prohibition against the prescribing of narcotics by medical and dental interns, as publicized in BUMEDNOTE 6120 of 10 Nov 71.

i. Updates Art. 23-2 and 23-60, the tabulations of Bureau reporting requirements and of Med. Dept. forms.

#### *Change 72 of 17 Dec 71*

This change completely revises Chap. 17, Deaths, which provides for use of civil death certificates for deaths in the U.S. and for use of NAVMED 5360/2, Certificate of Death (Overseas), for deaths outside the U.S. (BUMEDINST 5360.23, which provided interim procedures is superseded and will be canceled shortly.)

### BUMEDINST 1020.2 OF 14 MAR 72

*Subj: White pantsuits as optional uniforms for women members of the Medical Department*

This Instruction promulgates information regarding the approved white pantsuit as an optional indoor work uniform for Medical Dept. women officers and women enlisted Hospital Corps (Groups X and XI) who perform duties involving patient care.

### BUMEDNOTE 1520 OF 29 MAR 72

*Subj: FY 1973 NBC Defense and Disaster Preparedness Course for Senior Medical Officers; announcement of*

The subject course shall be conducted at the Naval Medical School, NNMCMC, Bethesda, Md. during the period 18-20 July 1972. The course is designed to accommodate up to 40 students and a Secret security clearance is required. Commands desiring to train a Medical Corps officer in aspects of NBC defense, mass casualty procedures, and disaster preparedness should request quota allocation. Requests should reach BUMED (Code 316) no later than 31 May 1972.

### BUMEDINST 1571.1B OF 25 FEB 72

*Subj: Program for two weeks' training period for members of the Nurse Corps, U.S. Naval Reserve.*

This instruction applies to NC reservists with or without prior active service. The subject training program shall be planned on an individual basis according to mobilization billet, if applicable, or specialty. Consideration should be given to the individual's preference for duty assignment if the officer has no specialty. Subject members may attend lectures and conferences for a two-week training period made available by the naval activity to which they are assigned.

### BUMEDNOTE 6120 OF 27 MAR 72

*Subj: Physical examinations incident to transfer of Navy and Marine Corps personnel and their dependents outside the contiguous 48 states*

It has come to the attention of BUMED that some members/dependents have been transferred to overseas locations or isolated areas in the U.S. who were not physically fit to perform all the duties of their grade or rate, or who required inpatient/outpatient care not available at or near their new duty station or deployment site.

This Notice emphasizes the importance of a thorough interview and physical examination of Navy and Marine Corps members before their transfer to duty outside the contiguous 48 states; to sea duty; or to units located within the U.S. which are likely to deploy to a combat or overseas location or other isolated area. The foregoing also applies to dependents who accompany their sponsor, either concurrently or subsequently to an overseas duty assignment.



Transferring activities are directed to insure that applicable directives are complied with.

#### BUMEDINST 6150.32 OF 20 MAR 72

*Subj: DD Form 183, Request for Clinical Follow-Up Information*

The DD Form 183 was devised and distributed to assist physicians and dentists desiring clinical follow-up information on patients treated for diseases/injuries of special interest, who were transferred to other facilities. The lack of response, however, has handicapped clinicians in the follow-up and study of patients who do not return to the originating medical facility. DD Form 183 is not for routine use and is limited to cases of a special professional interest. Responses thereto are a form of physician-to-physician professional correspondence and timely and adequate responses are a professional obligation.

Medical/dental officers will be provided the opportunity to request follow-up information through a check-off procedure on the clinical chart or other appropriate means established by the Patient Affairs Officer at hospitals or the Medical Administrative Officer at non-BUMED managed activities. The DD Form 183 will then be completed in accordance with the instructions thereon and will be appropriately forwarded to the destination hospital.

When DD Form 183 is received at the destination hospital, appropriate action shall be taken to establish control procedures leading to compliance with the request upon disposition of the patient.

#### BUMEDINST 6300.3 OF 10 MAR 72

*Subj: Inpatient Data System*

This directive provides revised instructions for reporting inpatient workload and morbidity data for Naval Hospitals, U.S. Naval Hospitals, and the Naval Submarine Medical Center. It will become effective on 1 July 1972. BUMEDINSTs 6310.5C and 6310.8A which are presently in effect, will then be cancelled and superseded. One reference copy of the cancelled instructions shall be retained until related records and reports are retired.

#### BUMEDINST 6300.4 OF 10 MAR 72

*Subj: Inpatient Data System*

This directive provides revised instructions for reporting inpatient workload and morbidity data for ships and stations having medical/dental personnel (less hospitals, U.S. Naval Hospitals and the Naval

Submarine Medical Center). It will become effective on 1 July 1972. BUMEDINSTs 6310.5C, 6310.7 and 6310.8A which are presently in effect, will then be cancelled and superseded. One reference copy of the cancelled instructions shall be retained until related records and reports are retired. NAVMED Form 6310/5 and report MED 6310-3 are also cancelled and superseded by this directive.

#### BUMEDINST 6550.3 OF 15 MAR 72

*Subj: Venipuncture Certification*

This instruction stresses the importance of certifying nurses for performing venipuncture and insures that suitable professional standards are established to guide programs conducted for venipuncture certification. The rules and regulations of any venipuncture program are the responsibility of the medical facility. However, there are certain minimum procedural requirements which must be followed.

All naval medical facilities having Nurse Corps officers and/or civilian nurses shall establish a program for venipuncture certification. Enclosure (1) of this instruction may be used as a guide in developing a program for local use.

Eligible nurses shall be certified in writing by the medical officer (or executive officer of a naval hospital). This venipuncture certification shall become a part of the nurse's official record and shall be renewed every two years.

#### BUMEDINST 6700.35 OF 4 FEB 72


*Subj: Repair and calibration of audiometric equipment.*

Promulgates procedures for obtaining repair and calibration of audiometric equipment from the Naval Aerospace Medical Institute, Pensacola, Fla., which has been assigned the responsibility for maintaining audiometric equipment in use throughout the Navy.

#### BUMEDNOTE 6710 OF 22 FEB 72

*Subj: Formulary Notes, Vol. I, No. 4.*

Enclosure (1) transmits additional listings of drug products classified as probably effective, possibly effective or ineffective subsequent to development of NAS/NRC-reviewed drugs.

One copy of Formulary Notes has been distributed to each officer of the Medical Corps, Dental Corps, and Pharmacy Section of the Medical Service Corps. 

## ✠ In Memoriam ✠

**CAPT Benjamin Benedict, DC, USNR (Ret.)** died 15 Feb 1972 at the Naval Hospital, Philadelphia, Pa. He was a native of Philadelphia, born there on 8 Jan 1894. He attended the University of Pennsylvania Dental School and in his senior year transferred to the Temple University School of Dentistry where he received his degree in 1917. In Dec 1917, he was commissioned a 1st LT in the U.S. Army Dental Corps and served with the American Expeditionary Forces in France. After the war Dr. Benedict returned to private practice and attained a reputation as an authority in prosthetic dentistry. He took an active interest in many dental societies, holding various positions and serving on several committees. In June 1938 he was commissioned a LCDR, DC, USNR and called to active duty in 1942. CAPT Benedict's name was placed on the Naval Reserve Retired List on 1 Jan 1957. He is survived by his wife, Elizabeth.

**VADM George W. Calver, MC, USN (Ret.)** died on 27 Feb at his home in Washington, D.C. He was a native of Washington, D.C., born there on 24 Nov 1887. He graduated from George Washington Medical School in 1912 and in Jun 1913, he was appointed Ass't Surgeon, LT(jg), USNR; he transferred to USN in Apr 1914. During the years prior to WW I, Dr. Calver served aboard the USS SUPPLY and on Yangtze Patrol in the USS PALOS and GALVESTON. At the outbreak of WW I, he returned to the U.S. and was stationed at Charleston, S.C. In 1927, after serving aboard several ships in the Atlantic Fleet, he reported to the Naval Dispensary, Navy Dept., Washington, D.C. Dr. Calver served there for ten years, with ADDU from Dec 1928 as medical officer in attendance at the House of Representatives during sessions of Congress. From May 1937 to Jul 1941, he was assigned to the National Naval Medical Center with ADDU as attending physician at the Capitol. He was subsequently relieved of the former duty, but continued to serve as medical officer in attendance upon the Congress. Dr. Calver was promoted to RADM in Oct 1945. Although transferred to the Retired List on 1 Nov 1947, he continued to serve on active duty in the same capacity and was promoted to the rank of VADM on 30 Sep 1966. He was relieved of active duty on 12 Oct 1966. For his service as attending physician to Congress, ADM Calver was awarded the Distinguished Service Medal. He also held the World War I Victory Medal, the American Defense Service Medal, the American Campaign Medal,

the World War II Victory Medal and the National Defense Service Medal.

Vice Admiral Calver was elected a Fellow of the American College of Surgeons in 1926, and a Fellow of the American College of Physicians in 1931. In addition to being a Fellow of the American Medical Association, he was a member of the District of Columbia Medical Society; the Southern Medical Society; the Association of Military Surgeons; American Heart Association; Society for the Study of Internal Secretions; Pan-American Medical Society; and American Soviet Medical Society. He held a certificate from the American Board of Internal Medicine and was an Honorary Consultant of the Army Medical Library. In 1963 in recognition of his 35 years as Physician to Congress, the Council of Federal Medical Directors for Occupational Health presented him with a certificate of honorary life membership.

ADM Calver is survived by his wife, Jessie; two daughters; ten grandchildren, and; two great-grandchildren.



LT Theresa M. Kistler, NC, USNR (dec).

**LT Theresa M. Kistler, NC, USNR**, drowned on 19 Feb 1972 while attempting to rescue her eight-year-old sister who also drowned at Leotjanni, a resort area in Sicily. LT Kistler was a 1969 graduate of Georgetown

University School of Nursing and had participated in The Navy Nurse Corps Candidate Program. After orientation at Newport, R.I., she was assigned to the Naval Hospital Philadelphia, prior to being stationed at the U.S. Naval Air Facility, Sigonella, Sicily. LT Kistler was married to James E. Kistler who is a dependent school teacher on the Sicilian base. At the time of LT Kistler's death, her parents and six brothers and sisters were visiting from Stamford, Conn. The tragic accident occurred while the family was preparing for a picnic lunch at the beach. An experienced Italian lifeguard also lost his life in the fatal attempt to rescue the young girl.

*RADM Don S. Knowlton, MC, USNR (Ret.)* died on 8 Apr 1972 at his home in Washington, D.C. Dr. Knowlton was born 6 Sep 1892 in Fairfield, Me. He attended Colby College, Yale University and Tufts University Medical School from which he graduated in 1921. Dr. Knowlton accepted a commission as LCDR, MC, USNR in 1930 and was a prominent physician in Washington, D.C., prior to reporting for active duty in 1940. After serving at the Marine Barracks, Quantico, Va., he was assigned to the FIRST Marine Division, Fleet Marine Force, and was Ass't Division Surgeon with the Marines who made the initial landing on Guadalcanal on 7 Aug 1942. For his exceptionally meritorious conduct during the seizure and occupation of Guadalcanal, Dr. Knowlton was awarded the Legion of Merit. He returned to the U.S. and served a tour of duty at the Medical Field Service School, Camp Lejeune, N.C., and in Oct 1944 returned to duty in the Pacific with the SIXTH Marine Division. Dr. Knowlton was

again awarded the Legion of Merit for performing outstanding services as Division Surgeon during the operations against the Japanese on Okinawa Shima, Ryukyu Islands. On 31 May 1946 ADM Knowlton was released from active duty and on 1 Mar 1950, his name was placed on the Honorary Retired List. After release from active duty, Dr. Knowlton returned to practice in Washington, D.C., until his retirement in 1965. He was an associate professor of otolaryngology at Georgetown University Medical School and a consultant to George Washington and Doctors Hospitals.

Dr. Knowlton was certified by the American Board of Otolaryngology in 1939 and was a Fellow of the American College of Surgeons. He was also a Fellow of the American Academy of Ophthalmology and Otolaryngology.

ADM Knowlton is survived by his wife, Mary.

*CAPT Andrew Wyda, Jr., DC, USN*, died at the Naval Hospital Portsmouth, Va., on 27 Feb 1972. He was 52. At the time of his death, CAPT Wyda was the Executive Officer of the dental department at the Naval Amphibious Base, Little Creek, Va. A native of Czechoslovakia, he served as an enlisted man in WW II. After graduating from the University of Pennsylvania Dental School in 1951, he received his commission in the Navy Dental Corps. Before his assignment to Little Creek in 1970, he served as Assistant Chief Dental Officer for Commander Submarine Force, Atlantic Fleet. CAPT Wyda is survived by his wife, Pauline; his mother, Mary; three daughters, Nancy, Carryty, and Susan, and; two stepdaughters, Marylin and Pamela Millerick. ☙

## ERRATA

Two unfortunate typographical errors were made in U.S. NAVY MEDICINE 59:3, Mar 1972, pp 34 and 40. The author's name on page 34 should have read *LCDR Carl J. Pepine, MC, USN* (vice LCDR Carl L. Pepine).

On page 40, column 1, paragraph 2, line 5, the footnote should have read 19 (vice 9).

We regret any inconvenience caused in connection with the splendid article entitled "Laboratory Evaluation of Angina Pectoris: Pathophysiological Considerations," by LCDR Pepine and CDR Bemiller. ☙

## SPRING SYMPOSIUM

We hear that the program for the Third Annual Spring Symposium at Nav Hosp Boston on 18-19 May 1972 is really outstanding. The call for papers was apparently heard around the world, and judging from the abstracts submitted, a highly selective collection of papers will be presented covering topics of timely interest in clinical medicine, dentistry, nursing and administration. We hope you're planning to attend. ☙



## United States Navy Medicine

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**MAKING THE SWITCH** — The apparent discrepancy in stripes results from a uniform change by Dr. Willard P. Arentzen signifying his promotion from Captain to Rear Admiral. Assisting the new Admiral off with the old and on with the new are his wife, Eleanor, and RADM Joseph L. Yon. Admiral Arentzen relieved Admiral Yon as Director/Commanding Officer of the Naval Regional Medical Center and Commanding Officer of the Naval Hospital. (Courtesy of PAO, Naval Regional Medical Center, Portsmouth, Va.)

**U.S. NAVY MEDICINE**